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GIVEN IN HONOR OF HIS PARENTS, THEIR SIMPLICITY
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————— BY EDUCATION. —————

WHAT WAY OF TEACHING IMMIGRANTS HABITS OF HEALTH
IS MORE EFFECTIVE IN AMERICA?

AMERICANIZATION STUDIES

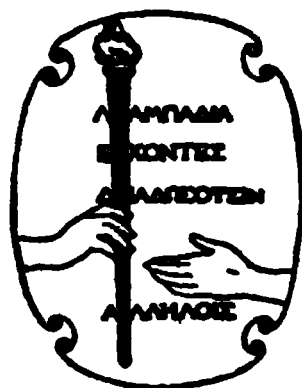
ALLEN T. BURNS, DIRECTOR

**IMMIGRANT HEALTH
AND THE
COMMUNITY**

BY

MICHAEL M. DAVIS, JR.

DIRECTOR, BOSTON DISPENSARY

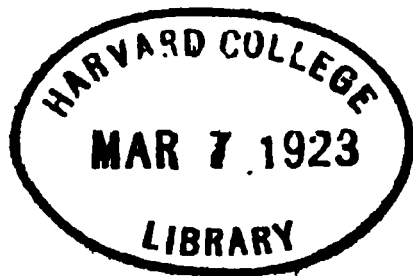


HARPER & BROTHERS PUBLISHERS

NEW YORK AND LONDON

1921

Med 4079.21



Jackson Fund

IMMIGRANT HEALTH AND THE COMMUNITY

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E-V

PUBLISHER'S NOTE

The material in this volume was gathered by the Division of Health Standards and Care of Studies in Methods of Americanization.

Americanization in this study has been considered as the union of native and foreign born in all the most fundamental relationships and activities of our national life. For Americanization is the uniting of new with native-born Americans in fuller common understanding and appreciation to secure by means of self-government the highest welfare of all. Such Americanization should perpetuate no unchangeable political, domestic, and economic regime delivered once for all to the fathers, but a growing and broadening national life, inclusive of the best wherever found. With all our rich heritages, Americanism will develop best through a mutual giving and taking of contributions from both newer and older Americans in the interest of the commonweal. This study has followed such an understanding of Americanization.

FOREWORD

THIS volume is the result of studies in methods of Americanization prepared through funds furnished by the Carnegie Corporation of New York. It arose out of the fact that constant applications were being made to the Corporation for contributions to the work of numerous agencies engaged in various forms of social activity intended to extend among the people of the United States the knowledge of their government and their obligations to it. The trustees felt that a study which should set forth, not theories of social betterment, but a description of the methods of the various agencies engaged in such work, would be of distinct value to the cause itself and to the public.

The outcome of the study is contained in eleven volumes on the following subjects: Schooling of the Immigrant; The Press; Adjustment of Homes and Family Life; Legal Protection and Correction; Health Standards and Care; Naturalization and Political Life; Industrial and Economic Amalgamation; Treatment of Immigrant Heritages; Neighborhood Agencies and Organization; Rural Developments; and Summary. The entire study has been carried out under the

FOREWORD

general direction of Mr. Allen T. Burns. Each volume appears in the name of the author who had immediate charge of the particular field it is intended to cover.

Upon the invitation of the Carnegie Corporation a committee consisting of the late Theodore Roosevelt, Prof. John Graham Brooks, Dr. John M. Glenn, and Mr. John A. Voll has acted in an advisory capacity to the director. An editorial committee consisting of Dr. Talcott Williams, Dr. Raymond B. Fosdick, and Dr. Edwin F. Gay has read and criticized the manuscripts. To both of these committees the trustees of the Carnegie Corporation are much indebted.

The purpose of the report is to give as clear a notion as possible of the methods of the agencies actually at work in this field and not to propose theories for dealing with the complicated questions involved.

TABLE OF CONTENTS

	PAGE
Publisher's Note	vii
Foreword	ix
Table of Contents	xi
List of Diagrams	xvii
Map	xvii
Chart	xvii
List of Tables	xix
List of Illustrations	xxiii
Introduction	xxv

PART I

CHAPTER

AMERICANIZATION AND HEALTH

I. THEORIES VERSUS PEOPLE	3
Psychological Factors in Health Work	4
The Big-stick Theory	10
The Laissez-faire Theory	15
The Democratic Theory	18

PART II

IMMIGRANT CONDITIONS AND POINTS OF VIEW

II. SICKNESS AMONG THE FOREIGN BORN	27
The Burden of Sickness	28
General Morbidity Statistics	31
Morbidity of Special Races	34
High Morbidity of Italians	36
Insanity Among the Foreign Born	39
Racial Differences Apparent	40

CONTENTS

CHAPTER	PAGE
III. DEATH RATES OF THE FOREIGN BORN	42
Racial Differences in Death Rates	43
Deaths from Degenerative Diseases	48
Pneumonia and the Acute Infections	50
Tuberculosis	53
High Mortality of the Irish	56
Low Mortality of Russians	57
Italian Death Rate Not Uniform	58
Infant Mortality	58
Need for Uniform Records	63
 IV. HOUSING VERSUS HEALTH	 70
Homes Available to the Immigrant	76
Prevalent Tenement Conditions	78
Boarders in Every Third Foreign-born Home	80
American Housing <i>vs.</i> Immigrant Health?	82
Testimony of Health Officers	84
Better Housing	89
 V. SELF-HELP AND HEALTH	 92
Racial Basis for Benefit Societies	93
Four Types of Benefit Societies	94
General Character of Societies	95
Church Keystone of Polish Societies	97
Italians from Same Village Unite	99
Nationalistic Interests of Jews	101
Hospital Care Among the Greeks	101
Firm Financial Basis of the Portuguese	102
Benefit Societies in Chicago	103
Benefit Societies Transitory	106
Inadequate as Health Agencies	107
Advantage in Friendly Assistance	110
 VI. IMMIGRANT BACKGROUNDS	 112
Peasant Origins	113
Public <i>vs.</i> Private Health Administration	117
Unfamiliarity with Medical Resources	120
New Relations to Government in this Country	121

CONTENTS

CHAPTER	PAGE
Changed Relation between Social Classes	122
Transition from Agriculture to Industry	124
Physiological Strain Due to Change in Environment	124
Unfamiliarity of Language	126
VII. IMMIGRANT RESOURCES FOR MEDICAL CARE	129
Home and Neighborhood	130
The Drug Store	131
Private Physicians	133
Inadequate Supply of Immigrant Doctors	135
Difficulties of Immigrant Practice	138
PART III	
SPECIAL IMMIGRANT PROBLEMS	
VIII. THE MEDICAL QUACK	145
Unscrupulous Methods	147
Exposure through Publicity	163
Responsibility of the Foreign-language Press	164
Federal Legislation	170
State Legislation	174
Law Enforcement	177
IX. BIRTH RATES AND MATERNITY CUSTOMS	184
Fecundity and Maternity Death Rates	184
Inadequate Maternity Care	187
Backgrounds for Motherhood	190
X. THE MIDWIFE	196
Reasons for Using the Midwife	199
Status of the American Midwife	203
Quality of American Midwifery	210
XI. ADEQUATE MATERNITY CARE	218
The Prenatal Clinic	221
Maternity Center Association of New York	223

CONTENTS

CHAPTER		PAGE
	Maternity Service by Medical Schools	225
	A Practical Plan	232
	The Cost of a Community Plan	233
	Districting the Service	238
	Visiting Housekeepers Essential	240
	Interpreting	241
	Advantages of the Plan	241
	The Co-operation of the Layman	243
 XII.	IMMIGRANT DIETS AND AMERICAN FOOD	 246
	Replacing Italian Food	253
	Jewish Religious Restrictions	257
	People of the Near East	264
	Poles and Other Slavic Peoples	270
	Application to Health Work	274
	Knowledge of Immigrant's Food Essential	275
	Need for Printed Material	275
	International Menus for Institutions	277
	Food Clinics Indispensable	278
PART IV		
AMERICAN AGENCIES AND METHODS		
 XIII.	FIELD WORK WITH THE IMMIGRANT	 283
	The Problem of Approach	284
	Barrier of Language	286
	Knowledge of Backgrounds	294
	Localization of Health Work	299
	Summary	302
 XIV.	THE HOSPITAL	 305
	Immigrant Attitudes	306
	Diets for the Foreign Born	311
	Uses of Interpreters	313
	Social-Service Department	318
	Immigrant Hospitals	321
	Need for a Community Plan	323

CONTENTS

CHAPTER	PAGE
XV. THE DISPENSARY	326
Use by Immigrants	330
Meeting the Needs of Individuals	334
Mediums of Communication	336
Importance of the Admission Desk	336
Social Service Department	338
Value of Food Clinic	339
Foreign-born Personnel	339
Need for Localization	340
Community Plan for Medical Service	342
Co-operation of Immigrants	343
 XVI. INDUSTRIAL HEALTH WORK	 344
Medical Service in Industrial Establishments	349
Accident Prevention	352
Benefits and Co-operative Plans	357
Extension of Service to Homes	360
Housing	362
Floating Labor Camps	365
The Pioneer Mining Community	368
Summary	371
 XVII. PUBLIC HEALTH WORK	 376
Experiments in New York	380
Health Centers in Cleveland	384
Co-ordination in Buffalo	385
A Dispensary in Boston	386
The Social Unit Plan	387
 PART V	
 A PROGRAM FOR HEALTH	
 XVIII. COMMUNITY ORGANIZATION	 393
The Economic Limitation	394
The Psychological Limitation	396
The Professional Limitation	398
The Social Limitation	399

CONTENTS

CHAPTER		PAGE
	Health Insurance	401
	Community Organization of Medical Service	404
	The Localization of Health Work	405
	Generalization in Field Work	406
	Service Organization	408
	Distribution of the Financial Burden	410
	Participation by the Community	413
	Preventive Medicine Fostered through Cura- tive	417
	A Small Community Program	419
 XIX.	 NATIONAL APPLICATIONS	 429
	Tasks for National and Local Organizations	429
	Need for a Central Standardizing Agency	432
	Training Health Workers	432
	A Clearing House for Information and Methods	433
	Stimulation of Local Organization	435
	Health Work and National Stamina	437
	No Inherent Racial Superiority	438
	Relative Birth Rate Unimportant	439
	Modern Fitness Defined	443
	Natural Selection Promoted	444
	The Democratic Process	446
	 APPENDIX	 449
	Recipes of the Foreign Born	449
	The Italians	449
	The Jews	451
	Armenians, Syrians, Turks, and Greeks	459
	Poles and Other Slavs	464
	 INDEX	 465

LIST OF DIAGRAMS

✓	DIAGRAM	PAGE
✓	1. Comparison for Each Mother Tongue of Foreign Born in the United States in 1910 and the Net Increase to July, 1919	6
✓	2. Proportion of Pneumonia and Other Respiratory Cases to All Cases Attended by Henry Street Settlement Nurses	36
✓	3. Variation by Nationality in Death Rates per 1,000, of All Males Five Years of Age and Over in New York City, 1917	46

MAP

✓	Peoples of Europe—Their Approximate Locations	65
---	---	----

CHART

✓	A Suggested Classification of the Foreign-born Population by Mother Tongue	66
---	--	----

LIST OF TABLES

TABLE	PAGE
I. Relative duration of illness among native and foreign-born white persons studied by the Illinois Health Insurance Commission	30
II. Physical rejections in alien and native communities compared	32
III. Report of physical examinations on drafted men in Local Board 129, New York City, 1919	33
IV. Cases of pneumonia and other respiratory diseases attended by nurses from Henry Street Settlement	35
V. Per cent of fourteen hundred New York school children showing low nutrition, 1907	37
VI. Per cent of children under weight in East Orange, New Jersey, by nationality of mother	38
VII. Comparison of race distribution in principal psychoses, 1918	39
VIII. Age distribution of the population of the United States, 1910	42
IX. Death rates per 1,000 population, by nativity, for registration area, 1890 and 1900	43
X. Death rate for white persons having mothers born in specified countries, 1900	44
XI. Death rate per 1,000 population of all persons five years and over, by nationality and sex, in New York City	45

LIST OF TABLES

TABLE	PAGE
XII. Death rates per 1,000 in principal nativity classes of New York State population, 1910	47
XIII. Death rate from certain diseases among whites, classified according to birthplace of mother, 1900	48
XIV. Death rate of whites from certain respiratory diseases and acute infections, classified by birthplaces of mothers, per 100,000 population, 1900	51
XV. Death rate of whites from consumption, per 100,000 population, 1900	54
XVI. Mortality of children under five years of age and under one year, in New York City in 1915, classified by birthplace of mother	61
XVII. Mortality rates of infants under one year classified by nationality of mothers, in three cities	62
XVIII. Per cent of households keeping boarders or lodgers, by general nativity and race of head of household	81
XIX. Independent foreign benefit societies in Chicago	105
XX. Periods in which 155 foreign benefit societies were founded	106
XXI. Number and characterization of quack advertisements translated from foreign-language newspapers	150
XXII. Percentage of advertising income derived from medical advertising in certain foreign-language newspapers	165

LIST OF TABLES

TABLE	PAGE
XXIII. Infant mortality in European countries, 1908	185
XXIV. Death rates from affections connected with pregnancy, 1900	186
XXV. Days in bed after delivery of cases cared for by midwives, New York City, 1912-19	189
XXVI. Births attended by midwives in New York State, according to the nativity of the mothers, 1916	197
XXVII. Fee rates for delivery of 285 cases, New York City, 1912-19	202
XXVIII. Death rates per 1,000 births for infants attended at birth by midwives, physicians, and hospitals, 1915-16-17	214
XXIX. The kinds of maternity care secured by patients of various races in New York, 1903-18	231
XXX. Number and per cent of 1,055 cases treated by the Central Free Dispensary, Rush Medical College, by nationality	331
XXXI. Number and per cent of 3,536 New York City cases using hospitals and dispensaries, by nationality	333
XXXII. Outstanding problems of the foreign born in industry, mentioned by seventy industrial physicians	348
XXXIII. Comparison of the weight and height of children of different ages living in Bourneville and Birmingham, England	362

LIST OF ILLUSTRATIONS

	PAGE
What Way of Teaching Immigrants Habits of Health is More Effective in America?	<i>Frontispiece</i>
Immigrants First Go to Live in Crowded Districts and Old Houses	73
In Peasant Countries Bathing and Washing were Done Out of Doors	86
Is It Any Wonder It Takes Time to Learn to Use a Bathtub?	87
In Europe Garbage and Waste were Burned or Fed to the Animals	118
In America Disposal of Refuse is a Public Function	119
The Immigrants Lived, Worked, and Played Out of Doors in Europe	125
Development Needed in Maternity Care	227
Nurse Must Relieve the Doctor in Caring for Many Babies Born	237
In Europe the Milk Supply was in the Front Yard	250
In America Milk from a Distance Makes New Re- quirements	251
Temporary Shanties May Be the Only Homes for Im- migrants in Mining Communities	369
Community Equipment for Health Education	411

INTRODUCTION

THE purpose of this book is to help interrelate the so-called Americanization movement in the United States with the many efforts toward the betterment of health conditions and the improvement of facilities for the care and prevention of disease. Americanization should include interplay between native and foreign born in all the important aspects of life, including the care and promotion of health. Therefore, the physicians, nurses, social workers, and administrators who are professionally concerned with medical and health work need to study people as well as technique, and adapt the policies and methods of their work to psychological as well as technical conditions.

The larger part of the book has been written by the undersigned, as chief of that division of the Americanization Study entitled Health Standards and Care. The writer accepts general responsibility for the book as a whole, due credit being given in this preface to the members of the staff or to co-operating specialists for the responsible parts which they have taken in collecting and summarizing material for particular parts of the book.

Miss Linda James was general assistant to the chief of this division of this study during the year and a half of its course. She is especially responsible for gathering the material on industrial medicine in relation to the foreign born, and for the statistical

INTRODUCTION

material in Chapters II and III. Dr. Walter H. Brown, Health Officer for Bridgeport, Connecticut, was responsible for the general survey of health departments; Miss Bertha M. Wood, head of the food clinic of the Boston Dispensary, for the valuable study of the dietary problems of a number of races; Miss Elizabeth C. Watson of New York for the midwife material, and Mr. Samuel M. Auerbach and Mrs. Janet Hayes Davis for the facts about the medical quacks.

The co-operation of several associations dealing with particular sections of our field proved of the greatest assistance. The National Organization for Public Health Nursing generously permitted one of its executive secretaries, Mrs. Bessie Ammerman Haasis, to devote a portion of her time as a member of the staff of this division to a survey of the policies and methods of visiting nursing organizations in relation to the foreign born. The American Association of Hospital Social Workers similarly allowed its executive secretary, Miss M. Antoinette Cannon, to give a portion of her time to a survey of the working methods of social-service departments with immigrant patients.

The helpful co-operation of the United States Public Health Service and the Bureau of Labor Statistics is cordially acknowledged. Dr. Harry E. Mock, president of the American Association of Industrial Physicians and Surgeons, generously gave much time in an advisory way to that part of the study concerned with industrial medicine. The number of individuals and of organizations who have assisted, by permitting us to analyze data which they had collected or by fur-

INTRODUCTION

nishing us original or published material of their own, has been too considerable to mention here, but an effort has been made to give credit and express appreciation in the text.

The compilation of material for this book was completed December, 1919, and this date should be borne in mind in considering the statistics and the discussion in general.

We are under deep indebtedness to the Harvard Medical School for generously furnishing comfortable office rooms for the staff of this division without charge for rent. The nature of this study has required visits to many parts of the country on the part of certain members of the staff, and hundreds of interviews with physicians in private practice, public-health officers, hospital superintendents, nurses, dietitians, social workers, officials and leaders in immigrant organizations, the priests and ministers of the churches, and, above all, with many immigrants themselves, medical or lay workers among their own race, or simply mothers or fathers or people who gave us something of themselves, their characteristics, their views, and their needs. The belief that America ought to see to it that its newcomers have facilities for better medical care and for more and better public-health work has been given a foundation which cannot be transferred to the reader by pages of statistics or of argument.

Much is said just now in criticism of the alien, particularly of the temporary residents in this country. But most of the immigrant men and women whom we have seen are raising their families here, and, though not losing their affection for the land of their birth,

INTRODUCTION

have burned their bridges against return. Interviews with them have left us with a sense of gratitude for the patience, the sympathy, the real understanding with which they have endured and responded to our questioning, and for the larger knowledge of human nature and human needs which they have given to us in much fuller measure than anything we have been able to return to them. The professional desire for better medical and health service to these foreign-born fellow citizens has thus been warmed and uplifted by the wish that they and their children shall share more fully than heretofore in the heritage of health and happiness of the New World.

MICHAEL M. DAVIS, JR.

CAMBRIDGE, MASSACHUSETTS,
July, 1920.

**IMMIGRANT HEALTH
AND THE COMMUNITY**

**Part I
AMERICANIZATION AND HEALTH**

IMMIGRANT HEALTH AND THE COMMUNITY

I

THEORIES VERSUS PEOPLE

"THE healthy know not of their health, but only the sick." With the advance of medical science this saying of the nineteenth century should be changed by the twentieth century to, **"The healthy learn to promote their health; the sick wish they had."** If a town is stricken with typhoid fever it must no longer blame Providence, but itself. Health can no longer be regarded as a negative or passive state, the mere absence of disease. Health is a positive quantity, an ideal of individual or community life, capable of being realized by methods which are more or less known.

This spread of knowledge has led in recent years to aggressive, organized movements for the care of illness and the promotion of health. The medical investigator, the executive officer of the health department, the hospital, the dispensary, the public-health nurse, the social worker, are all concerned with the study of medical methods and the application to

IMMIGRANT HEALTH AND COMMUNITY

the care and prevention of disease. Much of this study has to do with technique, such as periods and modes of quarantine, organization of hospitals, clinics, or sanatoriums, methods of prenatal care or of baby feeding. A large part of medical and health work depends for its effectiveness upon the careful, continuous study of just such impersonal matters of technique.

Without underestimating the value and necessity of technique, it must, nevertheless, be pointed out that effective medical and health work must take into account yet another element. The aim of medical and health work is to secure practical results in curing disease, reducing morbidity and mortality, promoting wholesome and efficient living. Work for these aims involves two fields of human knowledge. One is physiology, taken in the broad sense of that word. Medicine and its related sciences, such as bacteriology and chemistry, aim to ascertain the reactions of the human organism to various conditions of activity, climate, infection, and so forth. This constitutes what may be called the physiological field.

PSYCHOLOGICAL FACTORS IN HEALTH WORK

The other field is psychological or social. Medical and health work involves the application of science, or a group of sciences, to groups of human beings in both their individual and collective relationships. It deals with people and is administered by people. What the executives and field workers, what their patients and their public, think and feel about such work is fundamental in determining its extent and effectiveness at any given period.

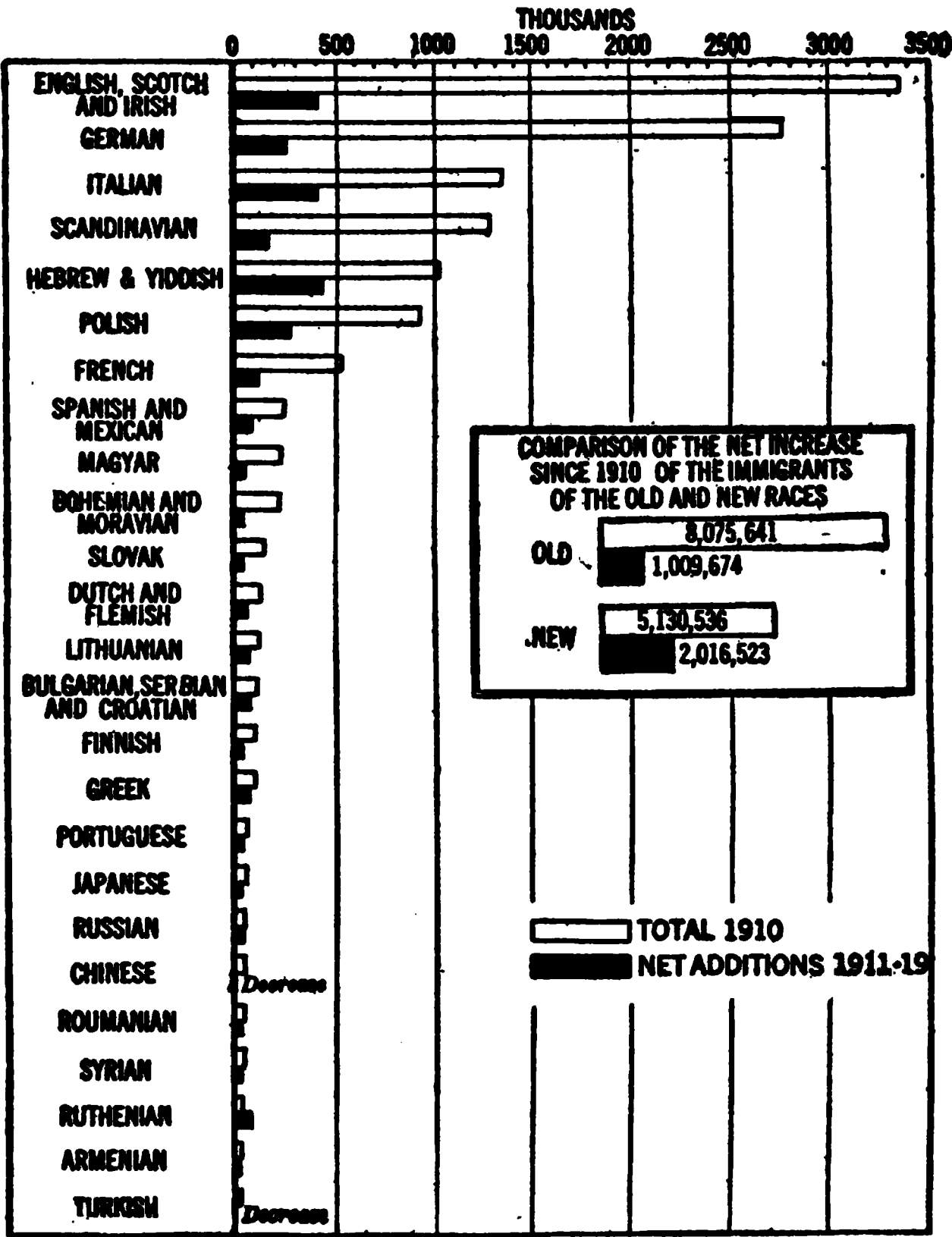
THEORIES VERSUS PEOPLE

The study of people is as important a factor in its success as are the nonhuman elements of technique. The health officer, the hospital superintendent, the public-health nurse, and the social worker, all being members of the human family, consider this human element in a more or less conscious way during their daily work. The extent to which they do this is a measure of what we commonly call their wisdom and tact. But beyond these individual considerations of personality, the sciences of psychology, economics, and sociology have a definite application to medical and health work. Inexact as these sciences are called, they yet bear lessons of importance for the physician or health worker. Conscious and deliberate research in this direction is urgently needed and will repay serious attention.

There are thirteen million foreign-born persons in the United States, and about twenty million more of foreign-born or mixed parentage. These people, because of their racial inheritance and their position as immigrants, have developed a psychology and live under social and economic conditions very different from those of the native born. For these reasons the problem of the human factor is intensified in medical and health work with the foreign element in our population. Also, they suffer more than the native born from failure to consider this factor, for American medical and health methods grew out of native conditions and so fit them at least approximately. The study of health problems among the foreign born here in the United States is, therefore, a necessary part of the investigation of Americanization methods, as well as a method of approaching the study of the

IMMIGRANT HEALTH AND COMMUNITY

DIAGRAM I.—COMPARISON FOR EACH MOTHER TONGUE OF FOREIGN BORN IN THE UNITED STATES IN 1910 AND THE NET INCREASE TO JULY, 1919, ACCORDING TO THE U. S. BUREAU OF IMMIGRATION REPORTS



human element in health technique within a field sufficiently definite and limited to be practicable.

Obviously the Italian, the Jew, the Scandinavian,

THEORIES VERSUS PEOPLE

the Pole, and the Syrian are not all alike. They differ in various physical characteristics, in language and traditions. They are human varieties, we may say. But is not health a problem of the human species? Have these human varieties, along with their admitted differences, any characteristically different problems of health or disease? In health matters, do they as a group differ from that other human variety known as native-born Americans?

These questions are partly answered by comparative statistical studies of sickness or mortality among different peoples here and abroad. In large part, however, they are answered by other kinds of data. Psychological and social differences between "races" or national groups, as contrasted with one another and with the native-born American, may be found to create the need for different methods of medical or health work.

This is the general problem. We deal with the specific situation in America. We seek to discover how far the foreign born present distinctive problems of health and disease and how our methods of medical and health work need to be adapted to the foreign born in order to secure the best results.

The characteristic qualities of different groups of our foreign born, and their condition in the United States, must be briefly reviewed, so that we may have a background of customs and traditions to which to relate matters of health and disease. The conditions and problems which are faced by those interested in medical and health work must be illustrated by field studies. Health departments, antituberculosis associations, industrial or commercial establishments doing

IMMIGRANT HEALTH AND COMMUNITY

medical or health work among their employees, must be considered from a technical point of view, to see how their methods have been adapted to the foreign born, or have failed to be so adapted. Examples of effective methods which might be of practical service if generally known, should be presented in some detail wherever possible. This is the case with problems of diet for the foreign born, a matter of great practical importance to hospitals and to health workers in the homes. So also with the urgent and picturesque subject of the medical quack and his all-too-effective methods among the foreign born.

The war forced Americanization upon the public attention. Some developed a definite conception of Americanization without much serious thinking. To them it meant teaching English and civics. It meant getting the immigrant naturalized. It meant making people Americans by putting them through certain instructions, crowned by the laying on of hands.

But the war made many others think about this matter. It brought them to see that Americanization implies more than mere instruction and more than naturalization. The assimilation of ten, twenty, or thirty million people into a nation of over one hundred million should mean mutual understanding, not the swallowing of one by the other. A common language must be achieved, but also mutually respected habits and standards of life. Full Americanization is impossible without an all-round transfusion of all the important elements in human life.

Health matters, as one of the important aspects of life, have an integral part in the process of Americanization. The numberless habits, customs, standards,

THEORIES VERSUS PEOPLE

upon which personal and family hygiene are based are of importance to the physician, and the health department, in relation to the care and prevention of disease. They are also everyday elements in determining the extent to which people are developing as Americans, members-in-full of an American community.

Have people such habits and standards of household life that if good housing is available facilities will be used and not misused? This question involves health and Americanization at the same time. Do people know how to use the facilities for the care of disease, such as, hospitals, sanitariums, clinics, well-trained private doctors? Or are people too ill informed to make the best use of what is available? This is not only a question of health. It involves the extent to which the people are intelligent participants in the American community. Are people intelligently co-operative with the school nurse, with the department of health, the infant welfare or antituberculosis agencies, public or private? Are people subject to the exploitations of medical quacks because of ignorance of good medical facilities combined with inability to read English? These, again, are matters of both health and Americanization.

Perhaps the chief difficulty in such a study as this is that of starting with a clean slate. Too many people have made up their minds concerning Americanization before thinking about it. It is easy to be led into a certain policy perhaps unconsciously, because of an a priori theory. We may hold in the backs of our heads cherished ideas about Americanization or about the differences between races. Consciously, or even un-

IMMIGRANT HEALTH AND COMMUNITY

consciously, we may have prejudices against certain kinds of people. Our attitude toward Americanization may be deeply influenced also by a fear of Bolshevism. Our selection and interpretation of facts, and our final conclusions, must not be determined by such preconceptions.

It is all too easy to let race prejudice or antagonism to foreign language be a controlling element in our judgments. This is particularly true when we are hardly conscious of our prejudices. It is well, therefore, to discuss, at the beginning, the three prevailing groups of preconceptions or "theories" about Americanization activities from the point of view of medical and health work especially. Such a review will render us conscious of the place and limitations of each theory, and we shall be less likely to be led astray without knowing it.

THE BIG-STICK THEORY

"Sorry to say it, but most of them must be scared into doing things." Thus the executive of a Western health organization sums up his policy of dealing with them—the foreign born. The health officer of a large city writes:

In most cases of contagion among foreigners, especially those who will not observe quarantine, we keep a quarantine officer in the neighborhood, who does not hesitate to arrest any offender, and generally after the first arrest we have no further trouble. This is a drastic measure, but it is the only efficient one we know.

A surgeon connected with a large industrial establishment says:

THEORIES VERSUS PEOPLE

What we need to deal with the health problems of the foreign born is adequate health laws and power to enforce them.

A health officer of a Middle Western city of moderate size says:

The foreign element in our city are most difficult to deal with because they are generally inclined to help themselves rather than accept skilled medical assistance and advice.

The same theory as that expressed in the previous quotations appears here by implication. It stands out still more plainly in the following, from a child-welfare bureau in a large Eastern city:

We have never modified the type of work to suit any special groups of people. We have always attempted to mold the groups to our way, so that our work would be uniform. We do, however, tell our workers never to encroach upon customs of different nationalities, if those customs do not conflict with our regulations or teaching.

An official from another large city writes:

In hospitals they [the foreign born] cannot be made to understand the treatment, and do not seem to improve under unfamiliar conditions.

A devoted worker, himself of foreign extraction, who has spent years of his life wrestling with this problem in great hospitals, illustrates his experience as follows:

Internes, as a rule, wonder how Polish mothers can be for ten years in America without knowing the language of the country. My answer was that those Polish mothers were exempted by the United States government by having brought forth and educated ten to twelve strong and healthy sons and daughters that are able to speak *two* languages.

IMMIGRANT HEALTH AND COMMUNITY

But our social workers are more severe in their judgment. In their fervor they would like to call upon the United States army and navy to do away with all those foreign languages.

What may be called the big-stick theory shows its head more or less frankly in these citations. This theory has taken on new vigor because of the war. Through its influence the continuance of foreign customs and ideas among people who have come to this country has been made to appear un-American or anti-American, and compulsion has been recommended as the remedy. These ideas find almost classic expression in the comic paper's recommendation to the worried mother when she wished to know how her children should take the necessary but disagreeable pills prescribed by the doctor:

How should they take 'em?
You hold their noses,
And step on their toeses,
And thus—you make 'em.

Analyzed more seriously, the big-stick theory seems to imply:

Americanism as a dogma.
Inferiority (of the foreign born) as a datum.
Uniformity as a social goal.
Compulsion as a method.

Undoubtedly a large number of persons feel that America is the best place in the world—Americanism the best thing—and they then proceed to the conclusion that Americans are persons like themselves,

THEORIES VERSUS PEOPLE

and that people who come to this country from elsewhere ought as quickly as possible to make themselves, or else be made, like Americans.

In health work the application of the big-stick theory means reliance upon police power, the enforcement of sanitary regulations by punishing people who violate them. It means trying to educate a community toward better sanitary standards by telling people what they must do and the penalties for not doing it. There are those who consider it un-American to use foreign languages in educational or health work, regarding this as a concession to the foreign born which is unwarranted, if not un-American.

Many big-stickers would protest that they do not hold the foreign born to be "inferior." Often a belief in inferiority is subconscious, but no less real. Sometimes it appears in the statement that the immigrant has no right to retain habits, customs, or traditions which he brought with him to this country. Oftener it is apparent when men are called "wops" or "hunkies," or in the mere tone in which immigrants are referred to. How does such a theory bear comparison with the Declaration of Independence?

Every important social group believes in itself. The conviction that "We are the people" is perhaps more characteristic of Americans than of others. The wish to make other people like this desirable model is a natural result. It takes time and effort to perceive that our true goal is not uniformity, but unity; not one vast note of blaring sound, but a harmony of many tones.

No sane man questions the necessity of authority and of its use under certain conditions. The strong

IMMIGRANT HEALTH AND COMMUNITY

hand of the law must and should deal with the careless consumptive who endangers his wife and children by promiscuous spitting about his home; the infectious syphilitic, recalcitrant to treatment and persistent in evil courses; or the family which maintains a gross sanitary nuisance. In such extreme cases the course of policy is clear. But, as a rule, it is important to determine the degree of authority which proves effective in securing results.

Is it best to teach by compulsion? When? How? Or do we get better results by some other method? The question at issue is not the presence or absence of the principle of authority from the armamentarium of medical or health work, but the manner and extent in which this instrument proves effective as compared with other means.

The use of compulsion as a method is one of those questions of degree which amount, in practice, to questions of principle. No sensible man objects to the proclamation of martial law under certain conditions. Martial law has its place among the instruments which a wise society will have at its command for use when necessary. But under what conditions is it necessary? How often? How much? Would we wish to live in a society in which martial law was the habitual method of administration? If not, let us seek to define its place, so that we shall know where and when to employ it, and when and where to avoid it.

If we proceed in medical or health work with the big-stick theory under our caps, we are likely to adopt policies and methods because we think they ought to work, without constantly testing them to see how they do work. Doubtless we all wish to attain a

THEORIES VERSUS PEOPLE

unified, harmonious community, with high standards of personal and public hygiene. What is the best method of attainment? The test of method in medical or health work is the same as in any other field of practical endeavor. Policies and methods must be tested by results.

The big-stick theory ought to be applied just as far as it will work—in a democratic society. And how far it will work is to be determined not by our preconceptions of policy, not by an a priori theory of Americanization, but by the dispassionate study of principles and the practical test of facts.

THE LAISSEZ-FAIRE THEORY

The traditional American, when not under pressure of war or the dread of some social upheaval, is an energetic individualist. He sees a chance to push himself ahead, and he admits the other fellow's right to the same opportunity. He follows the principle, live and let live, which in application to health work can best be expressed by the reverse, die and let die.

The *laissez-faire* theory is based partly on the optimism of ignorance. The belief is briefly as follows. The immigrants who have "the stuff" in them take care of themselves and become "Americans" without any great difficulty. The incapable must be taken care of anyway. America is the world's melting pot. All varieties of the human species have come here. The melting pot transforms all into Americans, like us who were born here. A piece of the philosopher's stone is always somewhere in the crucible, and turns every good bit of alloy into American gold.

IMMIGRANT HEALTH AND COMMUNITY

Frequent as are contemporary expressions of the big-stick theory of Americanization among medical and health workers, still more frequent expressions indicate the attitude of *laissez faire*.

"I hardly think it desirable to work out special diets for foreigners," writes the chief of dietetics in a large city hospital, "for I am told by the nurse that they do not complain of the meals served."

"This state has a large number of immigrants of all nationalities. We are not making any special effort to reach these people other than publishing certain literature in their native language," says the head of a state department of health.

The limitation in some cases of this kind is lack of funds rather than lack of desire, but many evidently feel with the health department of a large Middle Western city, that "Our foreign population is not a problem in any sense."

In application to health work the *laissez-faire* theory is illustrated by the health department, which provides various facilities, which is ever seeking larger funds, but which expects people to seek out what is provided. Investigations to determine what needs exist are rarely undertaken where this point of view dominates, nor are districts surveyed to discover what groups of people have or have not been reached by antituberculosis or infant-welfare campaigns. Neither is it likely that those imbued with this easy point of view will consider the foreign born as a special problem, the study of which is necessary in order to determine effective policies and methods.

"We object," said a health officer of a large city department, "to giving any special consideration to

THEORIES VERSUS PEOPLE

the health problems of the foreign born. This would be discrimination. Our aim is to treat everybody alike."

In almost the same words the superintendent of a large hospital stated his policy. These people remind one of the Dutch judge who said that it always troubled him to hear both sides of a case. It is easy to proceed upon the supposition that everybody is alike or near enough alike for practical purposes. Have in mind a standard. Consequently, have your scheme of sanitation or education or medical care. Maintain your standard. Offer your scheme. Let those who come to be benefited by the work profit by its blessings.

The *laissez-faire* theory, as applied to the field of medical or health work, means the assumption that the foreign born have no special health problems and that methods of health work need not be specially adapted to immigrant characteristics or needs.

No sensible person will question the value of throwing the responsibility for a man's success upon himself, or of expecting that those who wish to be blessed should seek the places of blessing. But here again the test of theory must be by results. The danger is that we mingle our prejudices with our practice instead of guiding our practice and controlling our prejudices by constant tests of efficiency in getting results.

In the descriptive portions of this book evidence will be presented to show that the presupposition of uniformity on which the *laissez-faire* theory is based is not correct. We shall endeavor to demonstrate that differences in health problems between native and foreign born exist, sufficient to warrant practical con-

IMMIGRANT HEALTH AND COMMUNITY

sideration; and that there are even wider differences in psychological and social reactions between native and foreign born which necessitate careful adaptation of methods to each group in order to secure the best results in medical or health work.

The *laissez-faire* theory is a useful corrective to the overeagerness of some reformers, but it is too simple to be true. As the Yankee who did not like French, translated it, the *laissez-faire* theory is a lazy theory, and not fair.

THE DEMOCRATIC THEORY

A new conception has taken practical shape in health work during recent years which we may call the 100-per-cent Idea. Suppose one thousand babies a year are born in a certain community. Suppose there is a bureau of child hygiene of the local department of health, or a private association doing infant-welfare work. Suppose the baby clinic or infant-welfare station had an attendance of one hundred and fifty different babies during the course of a year. How then shall the bureau of child hygiene or the infant-welfare association measure its results?

They may compare the death rates up to one year of age among the one hundred and fifty babies reached with the corresponding death rate among babies in the community at large. They may take pride if a reduction is shown. But if they have the 100-per-cent Idea in mind they will also be humble, because they have reached only 15 per cent of the community's babies. Their measurements of results will thus be more modest. Their program for future effort will be expanded.

THEORIES VERSUS PEOPLE

Possibly these people feel that the most needy babies were the very 15 per cent which their work reached; but that cannot be told without a canvass, a survey, of all the babies. Funds may not permit the work to reach 100 per cent. A certain proportion of parents may be too well to do to wish to have their babies "reached." But after all it is the principle on which the infant-welfare work proceeds that will determine its quality, its program, and the extent to which it ultimately realizes its program. The 100-per-cent Idea sets the goal and furnishes a yardstick for measuring annually the steps toward ultimate attainment.

A recent development in health work, which embodies the 100-per-cent Idea, is the health center. Essentially, the health center is an endeavor "to do things for everybody and to do things together, within a given district." In various forms these centers are being established throughout the country in increasing numbers. Previous to the war such cities as Philadelphia, New York, Pittsburgh, Cleveland, Cincinnati, Boston, Dayton, and others, had them in one form or another. The war necessarily interrupted progress, but its final effect has been a vast stimulant to medical and health work in almost all forms, the health center included.

In the cities and towns where health centers have been established the details have varied greatly. The idea of co-ordinating local health activities has been prominent in some. Infant-welfare stations, prenatal clinics, tuberculosis clinics, dental clinics, with their related medical and nursing services, have been brought together within a single building. Sometimes

IMMIGRANT HEALTH AND COMMUNITY

various other kinds of medical, educational, or philanthropic work have been brought within the center.

The idea of confining effort to a definite area and of doing intensive work for that area is also a characteristic feature of the health-center movement. The 100-per-cent Idea requires localization at the present stage of progress, where it is rarely possible to secure enough funds to reach a whole community intensively. Localization has brought with it a more intimate adaptation of the medical and health work to the needs of the neighborhood, with its various economic, racial, and other characteristics. It has necessitated the co-operation of individuals within the district, or of local, racial, social, fraternal, or other organizations. The utilization of psychological and social elements, as well as points of medical technique, is suggested, stimulated, and developed by the driving force of the 100-per-cent Idea.

A characteristic feature of the majority of health centers has been location in a district largely peopled by foreign born. In some cases the work is in an area where the great majority of the population are of a single race or national group. The health center started in 1915 by the New York Health Department was in the Jewish district of the lower East Side. The center of the Bowling Green Neighborhood Association is in a section largely Syrian. In Cleveland one health center is in the Hungarian section; one amidst Poles and other Slavs; others among mixed populations. Many other illustrations could be cited of health centers in areas inhabited by foreign born from different national or race groups, now one and now another predominating.

THEORIES VERSUS PEOPLE

No one imbued with the big-stick theory would start a health center if he realized what he was about. The 100-per-cent Idea requires a study of community needs, a canvass or survey of the district, and an appeal for local co-operation, such as can hardly be achieved by the use of mere authority. The health center is by no means the only manifestation of the democratic theory in medical and health work, but a real health center can only exist where there is a democratic idea in mind and an effort toward realizing it.

Some of the success of medical and health work depends upon the judicious use of authority, but more depends upon effective education. Much of the efficiency of a physician, a hospital, or a dispensary, in curing disease, depends upon how fully the patient understands the medical man's directions and advice. In the case of chronic disease the educational element is of the greatest importance, because old life habits must often be changed and new ones developed. In an acute disease the educational element is sometimes less obvious, but it is always present, especially during the period of convalescence. In all branches of disease prevention, the intelligent co-operation of the people is the greatest single element.

The diminution of typhoid fever in a city, through an improved water supply, depends on public support for the necessary financial appropriations. Considerable sections of a community may participate little in such an educational campaign and yet benefit by its results. But in the efforts against tuberculosis, infant mortality, the deaths and disabilities from child-bearing, the venereal diseases, cancer, the de-

IMMIGRANT HEALTH AND COMMUNITY

generative diseases of middle life, success depends fundamentally upon the extent to which the understanding co-operation of individuals can be secured.

Education is the foundation of success in these endeavors. Knowledge of the nature of various diseases, their modes of spread, and the methods of preventing infection, should be continuously sought. But a mass of existing knowledge is already on hand, waiting application to large groups in every community. Yet this knowledge lies fallow because too few of the people have been educated to understand the benefits that would follow its application and therefore to support the steps necessary to it.

We cannot educate with a hammer. The ruler has been abandoned as the chief instrument in educating children. The principle of interest is now the guide, not the principle of compulsion. This is still more true with adults. With them interested participation is essential to success. There must be a motive which creates interest, and a method on the part of the educator which maintains this interest and develops it. During the course of this study the most characteristic examples of successful health work with the foreign born are found to be closely connected with the principles of local co-operation and adaptation to community needs.

In its application to medical and health work the democratic theory requires that the physician, the health officer, the executive, the nurse, and the social worker must study people as well as technique. They must discover how far differences among people or between different groups of people require differences in methods, and what these differences are. A ready

THEORIES VERSUS PEOPLE

answer to these questions can spring forth from one's preconceptions. An answer more difficult of attainment, but far nearer the truth, will emerge from the study of people combined with an examination of practical results.

The results must be judged by the proportion of the population reached as well as by the effectiveness of methods upon those who are reached. Then the participation of individuals and of organizations will be enlisted locally or generally in a common effort for higher standards of health and of happy, efficient living. Then the health program will infuse itself into the program of Americanization, for these same principles are the right foundation of the general Americanization program.

Both in their application to the program of Americanization and also to the procedures of medical and health work, the principles of this chapter are based upon the idea that Americanism is not a quality, but an achievement. Its attainment must be through participation in a many-sided community life, in which individuals of all racial origins shall share, and to which each shall contribute.

People learn to adapt themselves to the common life chiefly by participation in some aspect of this life as individuals or as members of some organization. The agencies of government, and all organized co-operative activities for mutual benefit, must be adapted to serve individual needs. The principle of authority must be given its place, but the principle of democracy must dominate it. Then the mutual respect of individuals for one another will maintain freedom, while the sense of a common purpose will sustain law.

Part II
IMMIGRANT CONDITIONS AND
POINTS OF VIEW

II

SICKNESS AMONG THE FOREIGN BORN

MANY times the question has been asked: "What makes you think there is a health problem of the immigrant apart from that of the native born? What statistics have you to indicate any such thing?" That is a difficult question to answer, for there is a grave lack of statistical data, including racial factors. We know that sickness is a serious handicap to all workers, affecting native as well as foreign born. There is a general unanimity among the various studies that have been made as to the loss of time through sickness.

The U. S. Commission on Industrial Relations, 1915, estimated that "each of the thirty-odd million wage earners in the United States loses on the average nine days a year through sickness." This estimate corresponded closely to the statistical evidence from health-insurance systems abroad.

Since the report of this commission appeared, a number of studies have been conducted in the United States, and the estimate has been substantially confirmed.¹ Thus in the seven sickness surveys made by the Metropolitan Life Insurance Company among

¹ Margaret Loomis Stecker, *Some Recent Morbidity Data*, p. 22, Table VII.

IMMIGRANT HEALTH AND COMMUNITY

its industrial policy-holders, the average disabling sickness for each of the 376,573 persons over fifteen years of age was 8.4 total days, or 6.9 working days, per year. The recent study of some 40,000 members of the Workmen's Sick and Benefit Fund of America, conducted by the Federal Bureau of Labor Statistics, showed an annual average per member of 6.6 days of disability.¹ The number of days of sickness would, of course, be somewhat larger. Both the Ohio and Illinois health commissions estimated the average loss to be between 8 and 9 days.

THE BURDEN OF SICKNESS

But the burden of illness is not expressed by the number of days lost by the average wage earner. Some people are hardly ever sick, and during any given year only a certain percentage of persons fall sick. The problem arises because there is sufficient illness among this certain percentage of persons to cause serious loss, suffering, breakdown of ability for self-support, and breakup of families. What we practically need to know is the amount and extent of sickness.

The Ohio Health Insurance and Old Age Pension Commission, in a study of 663,163 members of benefit societies; the Illinois Health Insurance Commission, in an investigation of 4,474 wage earners in Chicago; and the Pennsylvania Commission, in a study of 743 families, including 3,198 individuals, of which 1,341 were workers—have thrown light on this subject. Both the

¹ "Disability Among Wage Earners," *Monthly Labor Review*, November, 1919, Bureau of Labor Statistics, U. S. Department of Labor.

SICKNESS AMONG THE FOREIGN BORN

Illinois and Ohio commissions estimated that about one worker in five lost more than a week's work through sickness. If 20 per cent of all workers suffer loss from this cause, the amount of sickness is found to be considerable. The average loss of time of all sick persons is estimated by the Illinois commission to be more than 50 days a year, and by the Pennsylvania commission to be about 40 days.

It must also be held in mind that the family of small income suffers most. In another study by the Illinois commission of a number of such families (comprising 3,475 persons), about four out of five suffered from sickness of the wage earner. Sickness of other members of the family added to the difficulty in more than two thirds of these cases. So it can be seen that sickness is a considerable handicap to the wage earners of the country, and especially to those getting the lower wages, large numbers of whom are immigrants.

Is the burden of sickness heavier among the foreign born than among native Americans? The evidence varies with race and with disease, but on the whole it is apparent that the immigrant bears at least as heavy a burden from sickness as does the native. Furthermore, the financial ability of the foreign born is generally less. Through the co-operation of Profs. H. A. Millis and Ernest W. Burgess, of the staff of the Illinois Health Insurance Commission, it was possible to make an analysis of about 12,000 cases. In several respects the data are not complete, but for the purposes of comparing duration of sickness of the native and foreign born the following table is fairly reliable:

IMMIGRANT HEALTH AND COMMUNITY

TABLE I

RELATIVE DURATION OF ILLNESS AMONG 2,385 NATIVE AND 9,211 FOREIGN-BORN WHITE PERSONS OVER FOURTEEN YEARS OF AGE, STUDIED BY THE ILLINOIS HEALTH INSURANCE COMMISSION.¹ (EIGHT HUNDRED AND FIFTY-FOUR NEGROES STUDIED—MAKING TOTAL OF 12,450)

DURATION OF ILLNESS	NATIVE WHITE		FOREIGN-BORN WHITE	
	Number Ill	Per Cent of All Ill	Number Ill	Per Cent of All Ill
Less than one week.....	3	0.7	2	0.2
One week.....	54	12.7	104	8.1
Two weeks.....	62	14.6	164	12.8
Three weeks.....	32	7.5	93	7.3
Four weeks.....	31	7.3	96	7.5
One month or less.....	182	42.7	459	35.9
One to two months.....	57	13.4	183	14.3
Two to three months.....	23	5.4	83	6.5
Twelve to fifty-three weeks.	49	11.5	151	11.8
Chronic illness.....	115	27.0	404	31.6
Total.....	426	100.0	1,280	100.0

It would appear from this table that the proportion of illnesses of long duration is somewhat larger among the foreign born of these Chicago families than among the native born. The difference of the per cents shown in chronic illnesses and those of a month or less, point in this direction and are apparently larger than would be accounted for by statistical errors.

Of course, no general conclusions can be drawn from a single small survey of this type; the data must be taken for what they are worth, and are presented largely to suggest that the elements of race and

¹ Illinois Health Insurance Commission, data furnished by Burgess.

SICKNESS AMONG THE FOREIGN BORN

nationality be included in succeeding sickness surveys. Results of considerable interest may be expected at a comparatively small additional cost of time and effort. There are other data that throw light on morbidity of the foreign born and answer some important questions.

GENERAL MORBIDITY STATISTICS

Probably the most far-reaching investigation which has compared the physical fitness of the native and foreign born is that made by the War Department in selecting drafted men for the army. The large numbers involved make the results reliable. To understand the statistics which are here cited it is necessary to know the definitions which the War Department gave to Groups A and D among the men examined.¹

Group A was composed of men who are vigorous and without any physical defect which might interfere with the full performance of military duties. Group D contained those who were found to have conditions which unfitted them for military service. This last group was made up in large part of those unfit also for most civilian occupations.

Later in the report it is stated that:²

For the purpose of comparing the physical qualifications of natives and aliens, a comparison was made of the rejections in local boards composed dominantly of natives and aliens, respectively. Some 85,000 examinations were assembled from local boards in dominant alien wards of the cities

¹ Second Report of the Provost Marshal General to the Secretary of War on the Operations of the Selective Service System to December 20, 1918, pp. 152-153.

² *Ibid.*, pp. 160-161.

IMMIGRANT HEALTH AND COMMUNITY

of New York, Philadelphia, Chicago, Cleveland, Milwaukee, and Cincinnati, representing a registration of 300,000. Then some 100,000 examinations were similarly assembled from other than city boards in the states of Indiana, Iowa, Kansas, Kentucky, and Ohio, representing also a registration of 300,000. The results were as follows:

TABLE II
PHYSICAL REJECTIONS IN ALIEN AND NATIVE COMMUNITIES
COMPARED

ALIEN AND NATIVE PHYSICAL REJECTIONS COMPARED	NUMBER	PER CENT OF REJECTIONS
1. Total number of records of examinations compared in dominant alien and native communities.....	184,854	.....
2. Rejected (Group D).....	28,184	15.25
3. Total compared, alien communities....	84,723	.....
4. Rejected (Group D).....	14,525	17.14
5. Total compared, native communities....	100,131	.....
6. Rejected (Group D).....	13,659	13.64

It is interesting to note that, as might be expected, this comparison is greatly to the advantage of the native Americans. In every 100,000 men the native born would yield 3,500 more (an additional regiment at war strength) for military service than would a like number of foreign born.

Although issue might be taken with the statement that there is "great advantage" to the native Americans in the comparison, it is apparent that there is a substantial difference between the per cent of rejections in native and alien communities.

An additional light on this subject is thrown by a report from local board for Division No. 129, New York City. This board, realizing a great opportunity,

SICKNESS AMONG THE FOREIGN BORN

made careful anthropometric studies of about 600 registrants. A preliminary report said:¹

Time has been lacking for a final study of the observed data. However, the figures seem to indicate that the foreign-born registrants were markedly less fit for service than the native born.

Since this report was written this local board has gone farther into the matter and summarized certain results which verify these preliminary conclusions:²

While the following data are based on a relatively few cases (397) the differences are too great to be considered mere accidental differences. They are real mathematical differences.

TABLE III

REPORT OF PHYSICAL EXAMINATIONS ON DRAFTED MEN IN LOCAL BOARD 129, NEW YORK CITY, 1919

	CLASS A		CLASS B		CLASS C		CLASS D		TOTALS
	PHYSI- CALLY FIT		REMEDIAL DEFECTS		LIMITED SERVICE		REJECTED		
	Num- ber	Per Cent	Num- ber	Per Cent	Num- ber	Per Cent	Num- ber	Per Cent	
Foreign born	34	37.0	4	4.3	35	38.0	19	20.7	92
American born:									
Foreign parents..	42	46.1	3	3.3	25	27.5	21	23.0	91
Mixed parents...	43	64.2	2	3.0	16	23.9	6	9.0	67
American parents	92	62.6	4	2.7	20	13.6	31	21.1	147
Total series....	211	53.1	13	3.3	96	24.2	77	19.4	397

¹ Second Report of the Provost Marshal General to the Secretary of War on the Operations of the Selective Service System to December 20, 1918, pp. 160-161.

² Dr. Louis R. Sullivan, American Museum of Natural History, *Analysis of Data Furnished by Local Board 129, New York City*, July 14, 1919. (Manuscript.)

IMMIGRANT HEALTH AND COMMUNITY

In Class A, which included all men who are physically fit, we find a greatly increasing percentage of men falling in this class as we pass from foreign born, and American born of foreign parents, to American born of mixed and native parents. These two latter groups are well above the average for the total series, while the two former are considerably below this average.

Class B is of little significance since it included only those with minor defects.

Class C included all men with a defect serious enough to be an impediment in general military work, but not necessarily in some special vocation. Here the percentage decreased from the foreign born to the American born of American parentage.

In Class D, which included all men with some defect serious enough to incapacitate them for all military service, and probably also most civilian vocations, we find small differences, yet these differences favor the Americans of mixed or American parentage.

MORBIDITY OF SPECIAL RACES

Considering how scant are morbidity data of any sort in the United States, we are fortunate in being able to present original figures from the Henry Street Settlement in New York City, relative to illness among the Italians and Hebrews. These two races predominate in the districts surrounding the settlement. Careful record by race was kept in 1916 of the cases of illness visited by the nurses from the settlement. The 17,380 cases were tabulated according to race, disease, deaths, and age distribution. The table given on the following page is made up from the full report.

When statistics are gathered for such a considerable number of cases racial differences become apparent. There is a heavy incidence of respiratory diseases upon

SICKNESS AMONG THE FOREIGN BORN

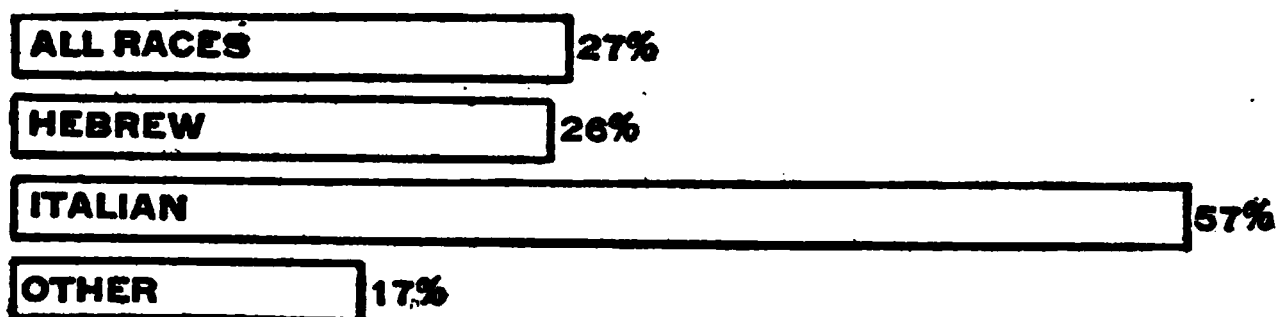
TABLE IV
NUMBER AND PER CENT OF CASES OF PNEUMONIA AND OTHER RESPIRATORY DISEASES, EXCLUSIVE OF TUBERCULOSIS, ATTENDED BY NURSES FROM HENRY STREET SETTLEMENT, NEW YORK CITY, 1916, FOR SIX AGE GROUPS AND TWO NATIONALITIES

Age Group	ALL NATIONS			HEBREW			ITALIAN			OTHER		
	Cases	DEATHS		Cases	DEATHS		Cases	DEATHS		Cases	DEATHS	
		Num-ber	Per Cent of Cases		Num-ber	Per Cent of Cases		Num-ber	Per Cent of Cases		Num-ber	Per Cent of Cases
Under 1 year:												
Number.....	909	106	11.7	296	17	5.7	361	64	17.7	252	25	9.9
Per cent.....	100.0	.....	.....	32.6	.....	.....	39.7	.....	.....	27.7	.....	.....
1 year:												
Number.....	1,246	84	6.7	374	6	1.6	535	57	10.7	337	21	6.2
Per cent.....	100.0	.....	.....	30.0	.....	.....	42.9	.....	.....	27.0	.....	.....
2-5 years:												
Number.....	1,212	46	3.8	369	5	1.4	526	28	5.3	317	13	4.1
Per cent.....	100.0	.....	.....	30.4	.....	.....	43.4	.....	.....	26.2	.....	.....
6-15 years:												
Number.....	684	10	1.5	174	.....	.....	264	2	.8	246	8	3.3
Per cent.....	100.0	.....	.....	25.4	.....	.....	38.6	.....	.....	36.0	.....	.....
16-20 years:												
Number.....	85	6	7.1	24	1	4.2	30	3	10.0	31	2	6.5
Per cent.....	100.0	.....	.....	28.2	.....	.....	35.3	.....	.....	36.5	.....	.....
21-45 years:												
Number.....	546	42	7.7	132	6	4.5	149	12	8.1	265	24	9.1
Per cent.....	100.0	.....	.....	24.2	.....	.....	27.3	.....	.....	48.5	.....	.....
Total.....	4,682	294	6.3	1,369	35	2.6	1,865	166	8.9	1,448	93	6.4
Per cent of all nations	100.0	.....	.....	29.2	.....	.....	39.8	.....	.....	30.9	.....	.....
Total cases of all diseases attended.....	17,380	692	4.0	5,293	89	1.7	3,692	281	7.6	8,395	322	3.8
Per cent of all diseases	100.0	.....	.....	30.5	.....	.....	21.2	.....	.....	48.3	.....	.....

IMMIGRANT HEALTH AND COMMUNITY

the Italians. Although they represent only one in every five people attended for any form of sickness, about two out of every five respiratory cases were Italians. This high per cent is found in each Italian age group, being highest for the groups between one year and six.

DIAGRAM 2.—PROPORTION OF PNEUMONIA AND OTHER RESPIRATORY CASES TO ALL CASES ATTENDED BY HENRY STREET SETTLEMENT NURSES



In the mortality from all respiratory cases we find a striking difference between Jews and Italians. The Jews have a per cent of 2.6 and the Italians of 8.9. Among children under one year only 5.7 per cent of Jewish children died as compared to 17.7 per cent of Italian.

HIGH MORBIDITY OF ITALIANS

The high rate of morbidity and mortality of Italians, both children and adults, is attested by several other studies.

Dr. Donald B. Armstrong, in a recent article about influenza,¹ spoke of the high morbidity rate from this disease and from pneumonia among the Italians in Framingham, Massachusetts. He found there that the Italians had suffered from a rate four times that of the rest of the population, which was chiefly Irish.

¹ D. B. Armstrong, M.D., Boston, "Influenza: Is It a Hazard to Be Healthy?" *Medical and Surgical Journal*, January, 1918, p. 65.

SICKNESS AMONG THE FOREIGN BORN

The prevalence of malnutrition and rickets among the Italians is strongly verified by the experience of numerous health agencies. In the investigation of the physical welfare of 1,400 school children, New York, 1907, the proportion of malnourishment cases varied in the several races.¹

TABLE V
PER CENT OF FOURTEEN HUNDRED NEW YORK SCHOOL CHILDREN
SHOWING LOW NUTRITION, 1907

	NUMBER EXAMINED	PER CENT
American.....	300	3.0
German.....	200	5.5
Italian.....	300	22.3
Jewish.....	300	11.3
Various.....	300	8.0
Total.....	1,400	10.4

The high figures for the Italians, which are over seven times that for the American child, tells its own story of underfeeding and lack of bodily vigor.

Some figures from East Orange, New Jersey, offer corroborative evidence:

Approximately 1,100 children were examined at the beginning of the local Children's Year campaign, and some interesting facts disclosed. One hundred and twenty-seven children, or 11.6 per cent of those examined, were found to be sufficiently under weight to require the attention of a physician. . . . The following table shows the per cent of children under weight when grouped according to the

¹ Frank A. Manny, "Nutrition Study," *Malnutrition and Race*, sec. xi, chap. G, p. 3, 1916.

IMMIGRANT HEALTH AND COMMUNITY

nationality of the mother, and presents some important figures:

TABLE VI

PER CENT OF CHILDREN UNDER WEIGHT IN EAST ORANGE, NEW JERSEY, BY NATIONALITY OF MOTHER

NATIONALITY OF MOTHERS	PER CENT OF CHILDREN UNDER WEIGHT
Sweden.....	4.3
Germany.....	7.7
Russia.....	9.1
United States, white.....	10.0
Italy.....	14.3
England.....	15.9
Ireland.....	20.5
United States, colored.....	22.6
All other countries.....	10.2

These figures present facts which correspond to previous general impressions, concerning which definite information was lacking.¹

Interviews carried on by this study, with doctors practicing in Italian neighborhoods, repeatedly reveal the great prevalence of rickets among the Italian children. Dr. Julius Levy writes of this in an article on the pre-school period. Dr. Antonio Stella of New York City has stated that 70 to 80 per cent of Italian children have rickets.² Were material comparable to that on the Italians available for other races, differences would doubtless appear, which would bring out the necessity for special provision and treatment.

¹ *Health News*, East Orange, vol. ii, July, 1918.

² Antonio Stella, M.D., "The Effects of Urban Congestion on Italian Women and Children," *New York Medical Record*, May 2, 1908

SICKNESS AMONG THE FOREIGN BORN

A great service can be rendered by gathering data on the differences of racial morbidity tendencies.

INSANITY AMONG THE FOREIGN BORN

Data on the occurrence of insanity among the native and foreign born are more extensive than on that of other diseases. A careful analysis of first admissions to hospitals for the insane was made by the New York State Hospital Commission in 1912. It was found that the frequency of insanity among the foreign born was 2.19 times as great as among the native throughout the state.

In 1918 again, the foreign born were admitted to hospitals for the insane considerably in excess of their proportion in the general population. The foreign born comprise 30.4 per cent of the population of New York State, and 46.4 per cent of all admissions to state hospitals were foreign born. Figures are obtainable on both the race distribution of all insanity and on the different forms of insanity.¹

TABLE VII
COMPARISON OF RACE DISTRIBUTION IN PRINCIPAL PSYCHOSES, 1918

PSYCHOSES	PER CENT OF TOTAL FIRST ADMISSIONS OF EACH RACE						
	Afri- can	Ger- man	He- brew	Irish	Italian	Sla- vonic	Mixed
Senile	5.2	11.6	5.8	13.2	6.2	1.6	10.2
General paralysis.....	21.3	17.3	13.3	9.9	19.1	6.7	13.1
Alcoholic	5.2	4.5	0.2	10.6	2.3	10.3	4.5
Manic-depressive.....	12.4	12.2	24.0	9.8	22.0	14.0	12.4
Dementia præcox.....	29.6	25.5	35.2	26.7	26.6	47.3	24.0

¹ *Thirteenth Annual Report of New York State Hospital Commission, 1918, p. 322.*

IMMIGRANT HEALTH AND COMMUNITY

From an analysis of this table it appears that certain races suffer considerably more from some psychoses than others. The Germans and Irish show the highest per cents of first admissions, due to senile decay; the Italians, Germans, and Hebrews, from general paralysis. For alcoholic psychoses the Irish and Slavs lead all the rest, a fact in entire harmony with the drinking habits of these races. Among the manic-depressives the Hebrews and Italians take first place. Slavs and Hebrews show very high rates from dementia præcox.

These figures, bringing out the marked variation among the different races, have no place in this study except to indicate the value of race statistics. They have been found valuable in the field of psychiatry and the treatment of psychoses. In the field of medicine similar data would be useful.

RACIAL DIFFERENCES APPARENT

In conclusion, the scarcity of morbidity data, taking into consideration the factor of race, should be emphasized. What little could be secured is not sufficient to establish many specific points, but enough has been given to indicate that there are racial differences in liability to certain diseases.

The general morbidity rate seems to be higher among the foreign born than among the native born. The Italians are afflicted with pneumonia and other diseases of the lungs more than other races, and succumb more readily to its ravages. This is especially true of the children of the pre-school age. Rickets, too, is a menace to the Italian children. Among the Irish, the Italians, Slavs, and Germans, insanity is a thing to be guarded against. How much these are distinctly racial factors; how much due to the eco-

SICKNESS AMONG THE FOREIGN BORN

conomic conditions under which our immigrants live—the housing and overcrowding, the change from one diet and environment to another—is uncertain. The data are yet inadequate for conclusions as to causes.

The paucity of morbidity statistics relating to race tells its own story of the great need for more careful record-keeping and research along these lines. Knowledge of what diseases attack which races, and why they do so, is vital to the success of all attempts to improve the health status of the immigrant.

III

DEATH RATES OF THE FOREIGN BORN

IN interpreting mortality statistics analyzed for racial factors, there are certain limitations which should be enumerated. Among them is the difference in the age distribution of the native population and of the foreign white stock. The following table, taken from the United States Census for 1910, shows this point:¹

TABLE VIII.

AGE DISTRIBUTION OF THE POPULATION OF THE UNITED STATES
(PERCENTAGES), 1910

AGE PERIOD	NATIVE PARENTAGE	FOREIGN OR MIXED PARENTAGE	FOREIGN BORN
All ages.....	100.0	100.0	100.0
Under 5 years.....	13.2	14.2	.8
5-14 years.....	22.6	24.1	4.9
15-24 years.....	19.7	21.6	15.8
25-44 years.....	26.2	27.6	44.1
45-64 years.....	13.6	11.2	25.4
65 years and over.....	4.4	1.4	8.9

The native population has a much larger per cent of children under five, babies especially, than has the foreign white stock. The latter, as a natural corollary, has a larger proportion of persons in middle life and in the later years.

¹ *Thirteenth Census of the U. S., 1910, vol. i, p. 298, Table XV.*

DEATH RATES OF THE FOREIGN BORN

Since infant mortality is an important factor in raising the general death rate of any community, the foreign born, who include practically no babies and a large proportion of the middle-aged group, whose death rate is notably low in most populations, might be expected to have a lower general death rate than the natives of native parentage. As a matter of fact, the reverse is true. The data collected by the United States Census in 1900 definitely established this conclusion. Nineteen hundred was the only year that a careful report of mortality data by race was printed by the Bureau of the Census.¹

TABLE IX
DEATH RATES PER 1,000 POPULATION, BY NATIVITY, FOR REGISTRATION AREA, 1890 AND 1900

WHITE ONLY	1890	1900
Both parents native.....	16.6	17.3
One or both parents foreign.....	16.6	21.5
Foreign born.....	19.4	19.4

Another factor affecting death rates is the sex distribution of the native and foreign born. In 1900 there were 102.8 native white males to every 100 native white females, while there were 117.4 foreign-born white males to every 100 foreign-born white females. On account of the higher mortality rate of males, the preponderance of this sex would tend to raise the general death rate of the foreign born.

RACIAL DIFFERENCES IN DEATH RATES

As notable as the differences in death rates between general nativity groups are those between races. The

¹ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, p. lxx.*

IMMIGRANT HEALTH AND COMMUNITY

following table shows the rates for persons whose mothers were born in various European countries. The difference in age distribution, particularly the large proportion of children among the native born, explains the fact that the rate for persons with mothers born in the United States is higher than for some of the other countries.

TABLE X
DEATH RATE FOR WHITE PERSONS HAVING MOTHERS BORN IN
SPECIFIED COUNTRIES, 1900¹

COUNTRY	DEATH RATE
Ireland.....	21.3
Italy.....	20.4
France.....	17.1
Scotland.....	15.8
Germany.....	15.5
Wales.....	15.5
United States.....	14.6
Hungary and Bohemia.....	12.9
Scandinavia.....	12.4
Russia and Poland.....	12.0

It is difficult to account for the wide variation evident in this table, on the basis of the facts in hand. Occupational, social, and economic influences are not easy to establish. Sharp changes in habits of living, in food, housing, and climate, undoubtedly leave their traces in mortality rates. Their relative importance to each race cannot be gauged at present upon a statistical basis. There are, however, a number of careful studies which shed more light upon our problem.

In 1917 Dr. William H. Guilfoy, Registrar of Records of New York City Department of Health,

¹ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, p. lxxi.*

DEATH RATES OF THE FOREIGN BORN

analyzed the statistics of the city with special reference to the effect of nationality on mortality.¹ The following table indicates his findings:

TABLE XI

DEATH RATE PER 1,000 POPULATION OF ALL PERSONS FIVE YEARS OF AGE AND OVER, BY NATIONALITY AND SEX, IN NEW YORK CITY

NATIONALITY	MALE	FEMALE
All.....	14.2	10.8
Irish.....	31.6	25.5
German.....	25.7	18.5
English.....	19.6	14.7
Native.....	13.4	9.8
Italian.....	9.8	8.5
Austro-Hungarian.....	9.8	7.0
Russian.....	8.4	6.6

Although this table and the 1900 census material quoted earlier are not strictly comparable, there are certain striking points of resemblance in the order in which we find the nationalities.

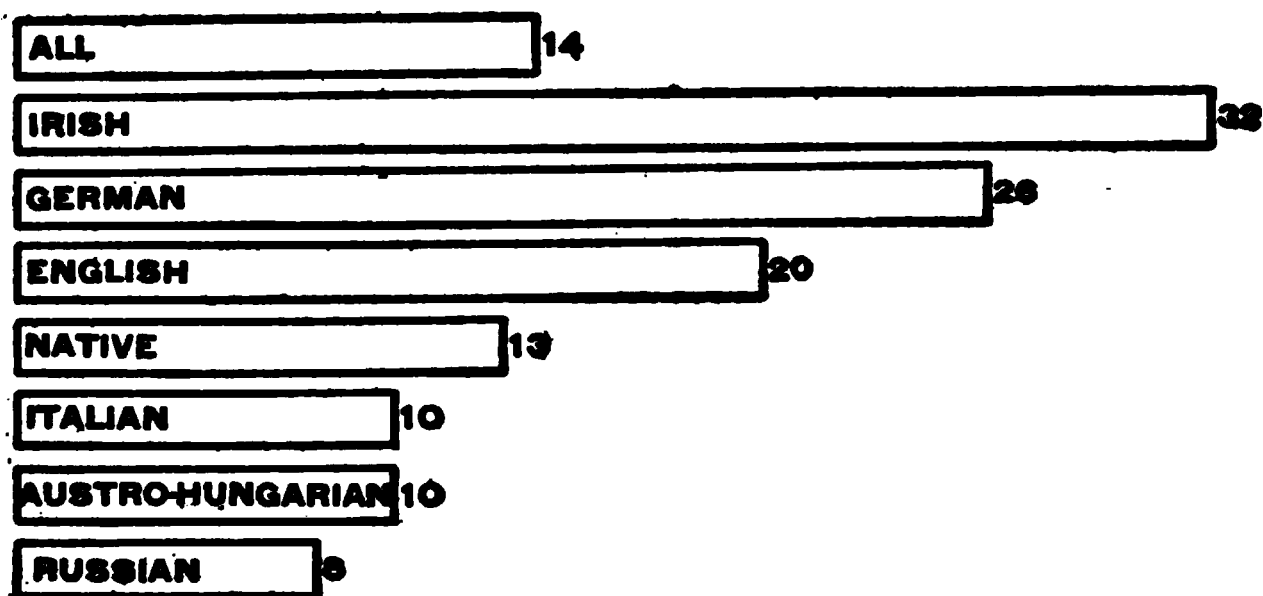
In both cases the Irish lead with the highest death rate. In both cases the Germans are found to have a higher rate than the native born, and the Hungarians a lower rate. At the bottom of both lists of nationalities come the Russians, with the lowest rate of all. The majority in this group are Jews. The Italian is the large nativity group which shows a striking discrepancy in the two tables. In the U. S. Census

¹ William H. Guilfoy, M.D., New York City Department of Health, "Influence of Nationality upon the Mortality of a Community," *Monograph Series No. 18*, November, 1917, pp. 20-24.

IMMIGRANT HEALTH AND COMMUNITY

table its death rate of 20.4 is next to the highest. In the New York City table the death rate for Italian males is 9.8, and females 8.5, figures less than half the earlier death rate. Further inquiry may illumine these points.

DIAGRAM 3.—VARIATION BY NATIONALITY IN DEATH RATES PER 1,000, OF ALL MALES FIVE YEARS OF AGE AND OVER IN NEW YORK CITY, 1917



Interesting material is furnished by Dublin in his study of death rates of persons in the older age periods, in which he contrasts the different races¹ (Table XII). Here again, a higher mortality rate than that of the native born is clearly shown for every race in the younger age group. In addition, the nationalities arranged according to highest male mortality rates in the first age period are in virtually the same order as in Tables X and XI. The Irish exceed the other nationalities by a wide margin, and Russians (largely Jews) are found second from the bottom of the list. The Italians show the lowest mortality rate in three of the four columns. This low rate corresponds with

¹ Louis I. Dublin, "Increasing Mortality after Age Forty-five," *Quarterly Publication of the American Statistical Association*, March, 1917, pp. 514-516.

DEATH RATES OF THE FOREIGN BORN

TABLE XII

DEATH RATES PER 1,000 IN PRINCIPAL NATIVITY CLASSES OF NEW YORK STATE POPULATION, 1910, BY AGE PERIOD AND SEX

NATIVITY	45-64 YEARS		65-84 YEARS	
	Male	Female	Male	Female
Native born of native parentage.....	18.8	14.3	77.3	68.2
Native born of foreign or mixed parentage.....	28.2	20.0	89.9	73.9
Foreign born.....	28.0	23.4	90.4	87.7
Ireland.....	46.3	40.7	101.6	107.4
Germany.....	27.7	18.4	90.4	83.1
England, Scotland, Wales.....	24.6	21.0	86.6	79.9
Austria-Hungary.....	21.0	18.2	77.5	63.9
Russia.....	20.1	16.0	78.4	69.8
Italy.....	19.3	17.9	64.6	63.8

the figure for the Italians in New York City, and contrasts with the figure for the country.

The nationality figure which shows a decided shift in its position in the three tables is the Italian. The figures could not be expected to coincide because of the variation in the bases; but the similarity in the order of the other nationalities is notable. Special causes no doubt operate in connection with the Italians, about which no figures are available at present.

Dr. William H. Davis, now with the Bureau of the Census in Washington, made in 1916 an illuminating analysis of mortality data for the city of Boston.¹ His conclusions are similar to those of Guilfoy and Dublin:

These rates, based upon the 1910 census and the deaths of 1910, present a picture of the influence of the foreign population almost identical with the picture based upon the

¹ William H. Davis, M.D., *The Relation of the Foreign Population to the Mortality Rates of Boston*, 1916, pp. 5-6.

IMMIGRANT HEALTH AND COMMUNITY

rates of 1900. Therefore, it is evident that these differences in the rates of various nationalities are not due to chance, but to actual differences in the peoples themselves, or in their occupations, or in their manner of living.

Some of the factors causing the differences or affecting the order of national mortality rates may be brought to light by considering the causes of deaths. Material is available showing the nationalities affected by the degenerative diseases—pneumonia and the acute infections, and tuberculosis.

DEATHS FROM DEGENERATIVE DISEASES

In the 1900 census, death rates from the chief degenerative diseases are classified for the different nationalities.¹

TABLE XIII

DEATH RATE FROM CERTAIN DISEASES AMONG WHITES, CLASSIFIED
ACCORDING TO BIRTHPLACE OF MOTHER. REGISTRATION
AREA, 1900

¹ Stomach, liver, and peritonitis.

² Heart disease and dropsy, angina pectoris.

³ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, p. lxxviii.*

DEATH RATES OF THE FOREIGN BORN

The outstanding feature of this table is the high death rate that the Irish show from all four causes. Their death rate of 17.7 from alcoholism is the most conspicuous fact of the table. This figure is almost double the next nearest in rank and partially accounts, no doubt, for the high rank of the Irish in the other causes of death, which in every instance obtains. Disregarding the figure for the French because so small a unit of population was included, we find the Germans, English, and Scotch following the Irish closely in a high mortality rate. At the other end of the scale are the Russians and Poles, who have the lowest rate of all nations from all causes except alcoholism, from which they have next to the lowest rate. It must be borne in mind that a large proportion of the Russians, and many of the Poles, are not Slavs, but Jews.

The ranks of the Italians remain comparatively low in the four columns, proving to be lower than the native born in every case. From these figures it is possible to prognosticate in a general way the causes of death in a community whose racial elements are dominantly any of those included in this table. This information again emphasizes the need of considering racial factors in practical attempts to lower mortality rates.

Both Dublin and Guilfoy come to much the same conclusions in their study of the influence of nationality upon mortality. Guilfoy finds in New York City that:¹

¹ William H. Guilfoy, M.D., "The Influence of Nationality upon the Mortality of a Community," *New York City Department of Health, Monograph Series No. 18*, November, 1917, pp. 20-21. See

IMMIGRANT HEALTH AND COMMUNITY

The males of the four countries—United States, Ireland, Germany, and England—show excessive mortality from these causes [alcoholism and cirrhosis of the liver]. The deaths among the Italians, Russians, and Austro-Hungarians are so few as to be negligible. . . . Considering the degenerative diseases, we find that the Irish males lead the mortalities with a rate of 1,010 (per 100,000 population), followed by the German males with a rate of 965, and an English male rate of 635, all considerably above the rate for all males. Irish females, German females, and English females also show higher mortalities than that of all females.

In conclusion it may be said that the foreign white stock suffer from a higher rate of premature deaths from the degenerative diseases than do the native born, and certain races, notably the Irish and Germans, show mortality rates from these diseases which far exceed those of any other group.

PNEUMONIA AND THE ACUTE INFECTIONS

Table IV in Chapter II, presented cases of pneumonia and other respiratory diseases attended by Henry Street nurses, as well as the number of deaths from these causes. There was a high per cent of deaths for Italians in all age groups, being 8.9 per cent, as contrasted with 2.6 per cent for the Hebrews. Especially notable is the high ratio (17.7) for Italian children under one year of age. The following table conclusively corroborates the evidence of their susceptibility to respiratory diseases and to acute infections as well:

also Louis I. Dublin, "Increasing Mortality after Age Forty-five," *Quarterly Publication of American Statistical Association*, March, 1917, pp. 514-518, 523.

DEATH RATES OF THE FOREIGN BORN

TABLE XIV

DEATH RATE OF WHITES FROM CERTAIN RESPIRATORY DISEASES AND ACUTE INFECTIONS, CLASSIFIED BY BIRTHPLACES OF MOTHERS, PER 100,000 POPULATION OF REGISTRATION AREA, 1900¹

BIRTHPLACE OF MOTHER	CAUSES OF DEATH								
	RESPIRATORY DISEASES			ACUTE INFECTIONS					
	Respiratory System ¹	Pneumonia	Bronchitis	Measles	Scarlet Fever	Diphtheria	Diphtheria and Croup	Whooping Cough	Cerebro-spinal Fever
United States....	211.6	142.8	35.7	11.9	11.0	30.9	40.7	14.0	8.6
Italy.....	705.5	479.8	175.6	62.6	15.5	48.7	67.4	20.9	11.2
Ireland.....	365.3	257.5	65.1	10.4	9.6	26.9	32.8	10.9	5.7
Hungary and Bohemia.....	272.5	206.6	33.5	8.8	13.8	37.4	49.2	8.4	4.9
Russia and Poland.....	268.5	197.6	40.8	13.5	18.4	39.6	49.7	11.7	7.6
Germany.....	245.7	161.1	47.0	8.9	7.6	29.0	37.7	6.9	3.9
England and Wales.....	228.7	156.9	36.7	7.9	8.3	19.7	25.4	10.1	5.2
Scotland.....	221.1	154.1	38.2	5.8	9.4	19.5	23.1	6.5	7.2
Canada.....	209.4	136.2	40.3	17.3	11.5	30.0	40.9	16.0	9.4
Scandinavia.....	209.8	148.3	33.0	13.4	13.6	35.6	44.6	16.1	8.4
France.....	208.6	145.7	38.9	2.0	8.0	10.0	11.0	6.0	5.0
Other foreign....	327.5	226.5	57.9	23.6	12.0	31.7	44.1	19.5	9.9

¹ Tuberculosis excluded.

The rates for the Italians from every cause of death are double those for almost every other race.

Guilfoy says, in his report on mortality in New York City, that the death rate from respiratory diseases among infants of Italian mothers is from two to three and a half times that among children of mothers of all other nationalities. Dublin also was much struck by the high general death rate of the Italians in New York State, and sought to discover the causes. He found that in practically every age period the

¹ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, pp. lxxvii, lxxxiii.*

IMMIGRANT HEALTH AND COMMUNITY

pneumonia death rate for Italians is about twice that of native Americans—sometimes the proportion is even greater. The differences are especially marked among women.

Like Abou Ben Adhem, Italy's name leads all the rest in this table. Since the fatal termination of many of the acute infections is due to some form of pneumonia, the high rates from these diseases may result from inaccuracy in reporting the immediate cause of death. In so far as this is the case, the rate from pneumonia is not nearly so high for the Italians as it should be.

Dr. Antonio Stella, in a block study of mortality among the Italians in New York City in 1908, found the same conditions there.¹ While the death rate from the acute respiratory diseases for the city was 12.7 per 1,000, for the Italians in the ten blocks studied it ranged from 17.9 to 49.0, and was usually over 30.0. From diphtheria, the city rate was 2.8, and the Italian 3.2 to 8.9, usually over 4.0. The broncho-pneumonia death rate for Italian children under five was two and one half times the American rate. The mortality from measles was five times the city death rate from that disease.

There are no such outstanding figures for any other nationality. The Irish rank second to the Italians in all the respiratory diseases, but they hold a low rank in the acute infections. Contrary to expectation based on the general mortality tables previously quoted, the Russians and Poles come near the first rank in deaths

¹ Antonio Stella, M.D., "The Effects of Urban Congestion on Italian Women and Children," *New York Medical Record*, May 2, 1908, pp. 722-732.

DEATH RATES OF THE FOREIGN BORN

from several of the causes listed. They rank first in deaths from scarlet fever and second in deaths from diphtheria and diphtheria and croup.

No other nationality has a consistent or striking rank according to cause of death. Even for the group whose mothers were born in the United States there are higher death rates from the acute infections than for a number of the other nationalities. With respect to the hazards of these diseases, one may parody the inquiry, "Does it pay to be healthy," by asking, "Does it pay to be native born?"

The fact that pneumonia, respiratory diseases—except tuberculosis—and the acute infections seem to play so fatal a part in the lives of the Italians in the United States, provides a practical point of attack for those who would lower general death rates among these foreign-born Americans and their children.

TUBERCULOSIS

The Irish are conspicuous in tuberculosis statistics by reason of their exceedingly high death rate from this disease (Table XV). Russia and Poland again stand at the foot of the list, having a death rate from consumption more than a third less than that of the United States, which in turn is the lowest of any nationality but one. This low mortality, if not immunity, from the great scourge of tuberculosis, is a fact to be remembered in health work with the Jews. It will be seen that the death rate among the Irish is more than three times that of those whose mothers were born in the United States, and almost twice that of any other race.

IMMIGRANT HEALTH AND COMMUNITY

TABLE XV

DEATH RATE OF WHITES FROM CONSUMPTION, PER 100,000
POPULATION OF REGISTRATION AREA, 1900¹

BIRTHPLACE OF MOTHER	CAUSE OF DEATH
	Consumption
United States.....	112.8
Ireland.....	339.6
France.....	184.7
Scotland.....	172.5
Germany.....	167.0
Canada.....	143.1
England and Wales.....	135.1
Italy.....	113.6
Hungary and Bohemia.....	107.7
Russia and Poland.....	71.8
Other foreign.....	153.8

Guilfoy speaks of the fact of high mortality of the Irish in his article on the influence of nationality on mortality in New York City.²

The death rate at all ages . . . from pulmonary tuberculosis is noteworthy by reason of the excessively high rate among the Irish males; 701 out of every 100,000 died as compared with 333 native males . . .

Dr. Donald B. Armstrong, in the course of the tuberculosis experiment conducted during the past three years in Framingham, Massachusetts, found the same excessive death rate for this race.³ Analysis of

¹ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, p. lxxxviii.*

² William H. Guilfoy, M.D., "The Influence of Nationality upon the Mortality of a Community," *New York City Department of Health, Monograph Series No. 18*, November, 1917, pp. 20-21.

³ "Vital Statistics," *Sanitary Series No. 1, Framingham Monograph No. 3*, Appendix A, Tables IV and XIII.

DEATH RATES OF THE FOREIGN BORN

his data shows that although the Irish stock represents only 16.5 per cent of the population, they supplied 28 per cent of the deaths from tuberculosis for 1907-16. He also points to the low death rate of the Russians (Jews) in Framingham.

In Table XV the death rate from tuberculosis of the Italians is 113.6. This figure is about that of the native born, and is fourth lowest in the scale for all nationalities. The low death rate from tuberculosis of the Italians is brought out in other studies. In the Framingham study mentioned above, Italians represent 7.7 per cent of the residents, and only 5 per cent of the deaths from tuberculosis.

This fact seems particularly remarkable in view of the extremely high Italian death rate from diseases of the respiratory system, noted in Table XI, Chapter II, and Table XIV of this chapter. One supposition is that the Italian goes back to Italy as soon as he learns that he has tuberculosis. Many doctors interviewed by the study testified to this fact. Stella states that of 81,412 Italians returning to Italy in 1906, about 450, or 5.61 per 1,000, were advanced cases of this disease.¹ When the Italian, particularly the southern Italian, falls ill with tuberculosis, memories of the home people and of sunny hills seem to pull him back with irresistible force to die in Italy. Such considerations, impossible of statistical classification, may account for many of the figures. In summarizing the scattered data presented in this chapter

¹ Antonio Stella, M.D., "The Effects of Urban Congestion on Italian Women and Children," *New York Medical Record*, May 2, 1908.

IMMIGRANT HEALTH AND COMMUNITY

we shall see how they relate to the principal racial groups.

HIGH MORTALITY OF THE IRISH

From data in the earlier part of the chapter the high death rate of the Irish was apparent. In the census figures of 1900, and in later figures for both New York State and city, this race stands consistently first among nationalities ranged in order of mortality rates. This rank is the more striking because the rates are about twice as large as comparable figures in Ireland. What elusive influences play upon this race as it is transplanted to another land, it is difficult to discover. A closer picture of conditions can be obtained from the figures on causes of death.

Alcoholism, as a cause of death among the Irish, is the outstanding feature of Table XIII. This race also takes primary rank in deaths from other diseases, such as Bright's disease, those of the digestive system, the circulatory and respiratory systems, as shown in Tables XIII and XIV. Ireland heads the death rates from consumption, showing a rate almost twice that of the next nearest figure, as seen in Table XV. In Doctor Davis's study of mortality in Boston, referred to above, the same excessive mortality of the Irish was noted.

Whether there is a relation between the high figure on alcoholism and susceptibility to these diseases is problematical. At least, their coincidence is suggestive. Since the Eighteenth Amendment to the United States Constitution has been passed, another decade may throw more light on these conditions. Less outstanding, but equally to be noted, is the comparatively

DEATH RATES OF THE FOREIGN BORN

low rank (Table XIV) the Irish hold in deaths from the acute infections. Here they consistently show a lower rate than the native born. This, too, is a fact to be held in mind in considering racial differences.

LOW MORTALITY OF RUSSIANS

In contrast to the mortality rate of the Irish we find that of the Russians at the bottom of the list. They rank low in the census data for 1900, when they are classified with the Poles; they are found at the bottom of the table for New York City, and rank among the lowest in the table for New York State. The Russians include a large proportion of Jews (about half of all the Russians in the United States in 1910 were Jews, and in New York City the proportion is much larger), and Jews generally show a lower mortality rate than any nationality among which they live. Whatever may be the explanation of this fact, it accounts for the figures here presented.

In the tables showing causes of death the Russians do not maintain a fixed relation to the other nationalities. They are found at the foot of the list for the so-called degenerative diseases, showing in each case a lower rate than the native born (Table XIII). For the respiratory diseases they rank fifth in each case. To the acute infections they show a much higher susceptibility.

It is hard to trace this high mortality to any measurable factor. Such explanations as congested and unsanitary living conditions are at best mere surmises. The strikingly low death rate from tuberculosis, which is about a third less for these people than for

IMMIGRANT HEALTH AND COMMUNITY

those of native mothers, is a fact of no slight import. Exposure to urban conditions for many generations, and consequent elimination of stocks unable to resist the prevalent urban infections, is a probable factor in this low rate among the Jews.

ITALIAN DEATH RATE NOT UNIFORM

The Italian death rate varies more than the Russian. For the degenerative diseases it is lower than that of the native born. In the consumption table we find the Italian death rate about equal to the native, a figure which is low compared to the other races. But for the other respiratory diseases and the acute infections, the Italians have the highest rate, with one exception, of any racial group, varying from over five times that of the native group to slightly less than it.

This range in mortality rate, from less than the native to over five times it, is analogous to what is commonly considered the volatility of the Italian temperament. Perhaps the return of the Italian to Italy, when he knows he has tuberculosis, fully explains the low figure for that disease. The causes affecting death rates, with this race as with all, must be widely sought in general attitudes and aptitudes, as well as in physical conditions of living and working. The present brief outline of available data has served its purpose if it has indicated racial variations and the possibility of further inquiries.

INFANT MORTALITY

The final group of mortality statistics to be discussed here is that relating to infants. The first question to

DEATH RATES OF THE FOREIGN BORN

be answered is whether or not babies of the foreign born show a higher death rate than those of the natives.

According to the 1900 census the children born of native parents had 135.3 deaths to every 1,000 births; those born of parents, either one or both of whom were foreign born, had 149.2; those born abroad had 141.1.¹ The figure for the foreign-born babies need not be considered, as the number of children under one year brought to the United States and dying here is small, only about 400 for the whole registration area as against 37,000 deaths among native-born babies of foreign parents. The other two figures are comparable, and indicate clearly that infants of foreign parentage suffer from a higher mortality rate than those of native parentage.

In 1919, Eastman, of the New York State Department of Health, made an analysis of the infant mortality statistics for that state, in order to see whether or not there was any connection between race and infant mortality rates. The report is full of tables, with careful interpretations by the author, which are too long for reproduction here. Certain of Eastman's observations and conclusions will be quoted.²

It appears [he says] that the mortality of babies under one month old is higher among those born to native mothers than among children born of women of foreign nativity. Although the mortality of children less than one year of age born of native women was only 87 per 1,000 births,

¹ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, pp. lxxxviii and 286.*

² P. R. Eastman, *The Relation of Parental Nativity to the Infant Mortality of New York State*, American Medical Association, 1919.

IMMIGRANT HEALTH AND COMMUNITY

compared with 108.4 for children of foreign-born mothers, the rate under one month for the former was 47.4 as against 45.2 for the latter. Attention is also directed to the fact that the infant mortality of the children of native mothers more than one month of age and less than one year old, was only 39.6 contrasted with 63.2 for babies born to foreign mothers. . . .

The infant mortality from communicable diseases was almost 75 per cent greater among children of foreign mothers than among the babies of native mothers; from respiratory diseases it was more than 100 per cent greater, and from gastro-intestinal diseases the excess was about 78 per cent; but the rate from prenatal and other causes peculiar to early childhood was higher among the native element by more than 20 per cent.

There is further analysis of the New York State figures, but the main fact is this, there is a measurable difference in resistance between children of native and of foreign parents for both age periods under one month and between one month and one year. Examination of these differences leads to the conclusion "that the chief causes of infant mortality among the native population originate for the most part in adverse prenatal conditions, but that among the foreign element the most frequent causes of deaths are communicable, respiratory, and gastro-intestinal diseases."

Turning again to Guilfoy's figures for New York City, we find the same wide variation among the races that appeared in his total mortality data. The following table sums up his findings:¹

¹ William H. Guilfoy, M.D., "Influence of Nationality upon Mortality of a Community," *New York City Department of Health, Monograph Series No. 18*, November, 1917, p. 24.

DEATH RATES OF THE FOREIGN BORN

TABLE XVI

MORTALITY OF CHILDREN UNDER FIVE YEARS OF AGE AND UNDER ONE YEAR, IN NEW YORK CITY IN 1915, CLASSIFIED BY BIRTH-PLACE OF MOTHER

BIRTHPLACE OF MOTHER	DEATHS PER 1,000	
	Under Five Years (Rate)	Under One Year (Rate)
Italy.....	42.5	103
England.....	40.5	138
United States.....	40.0	106
Ireland.....	36.8	119
Germany.....	32.3	115
Austro-Hungary.....	26.3	79.8
Russia ¹	24.9	77.9

¹ Figure includes Polish.

Here the rank of Italians and the low rank of Russians, with their preponderant numbers of Jews, corresponds with the total death-rate tables quoted earlier in the chapter.

The most intensive studies in the field of infant mortality, from a social rather than a medical point of view, have been made by the Children's Bureau. Racial differences are apparent in these, as the briefest reference to the findings of the studies made in Manchester, Johnstown, and Brockton will indicate. The following table compares the death rate for the children under one year of age, of native and foreign-born mothers, in these three places. We find here wide variation among the three towns, especially for the rate of children with foreign-born mothers, which is twice as high in Manchester as in Brockton. The range is not so great in the three towns between those of native mothers. The rates

IMMIGRANT HEALTH AND COMMUNITY

of the different cities are not exactly comparable, since the surveys were made in three different years.

TABLE XVII

MORTALITY RATES OF INFANTS UNDER ONE YEAR CLASSIFIED BY NATIONALITY OF MOTHERS IN THREE CITIES, STUDIED BY CHILDREN'S BUREAU ¹

CITY	RATE PER 1,000	
	Native	Foreign Born
Manchester, New Hampshire....	128.1	183.5
Johnstown, Pennsylvania.....	104.3	171.3
Brockton, Massachusetts.....	101.5	92.0

It is common to find the death rates of the native born lower than those of the foreign born. This is true in two of the places listed, but not in Brockton. At the same time, stillbirths were twice as numerous among the foreign born as among the native born. More detailed analysis would be needed fully to explain this variation. Brockton is a prosperous shoe-manufacturing town where almost half the foreign born come from English-speaking countries. This might explain the lower foreign-born rate.

The high figure for Manchester is largely due to the high death rate (224.7) of French-Canadian mothers. The single race that brings up the figures for Johnstown is that for the Serbo-Croatian mothers, who have a rate of 263.9. In the case of Manchester the French-Canadians are "generally thrifty, self-respecting people, ambitious to own their homes and to accumulate property. . . . On the whole, they occupy

¹ Beatrice Sheets Duncan and Emma Duke, "Infant Mortality, Manchester, New Hampshire, 1917"; Mary V. Dempsey, "Infant Mortality, Brockton, Massachusetts, 1918"; Emma Duke, "Infant Mortality, Johnstown, Pennsylvania, 1915"; Children's Bureau, United States Department of Labor.

DEATH RATES OF THE FOREIGN BORN

a relatively favorable position among the foreign born in the community as regards both economic and social status. . . . Their larger death rate may be accounted for by their large families and the prevalence of artificial feeding."

On the other hand, the Serbo-Croatians in Johnstown live in congested and badly equipped quarters, where the small proportion of women in their number bear the brunt of the poor housing facilities. How far these various conditions account fully or in part for the death rates in different places and among different races cannot be asserted except after further study. In any particular locality it is evident that special study will be profitable as a basis for planning health programs.

NEED FOR UNIFORM RECORDS

All available morbidity and mortality data classified by race show very definite differences. These differences vary with diseases, places, and ages, but everywhere they become apparent. Whether these and others less noticeable are due to racial tendencies or characteristics, or whether they are due to the various environments in which different race groups find themselves in this country, is a matter on which there is not sufficient evidence to support an opinion.

Whatever the causes, the observed differences are sufficient to be of practical importance to the health officer, the clinical physician, the visiting nurse, and all others concerned with medical and health work. A health officer, for instance, who starts a campaign to reduce morbidity and mortality from respiratory diseases, without having analyzed the race elements

IMMIGRANT HEALTH AND COMMUNITY

in his community, and without knowing the relative susceptibility to these diseases of the native born, the Irish, the Italian, is likely to waste some effort and misdirect much more.

The most significant conclusion to be drawn from our brief statistical survey is the relative paucity of information. All the investigations which have been cited make only a small contribution to a few points in a large subject. A much larger body of data should be collected before many final conclusions can be stated. Further statistical investigation can be made in two ways: first, by special studies undertaken with particular ends in view, such as comparison of sickness or death rates from particular diseases; second, by including and analyzing the race elements in the masses of vital statistics which are more or less automatically collected by departments of health and many private organizations.

One of the most general difficulties in this work is finding uniform designations for the so-called race groups. The present practice, as shown in the reports of different health departments, hospitals, dispensaries, nursing, and other organizations, has no uniformity. In only a few countries, such as England, are the political and race boundaries the same. A person born in Austria-Hungary may be a German, Magyar, Slovak, Bohemian, Jew, Croatian, Rumanian, or even an Italian. The inhabitants of that one country speak many tongues and come to this country with varying heritages.

On the other hand, mother tongue alone is not a sufficient designation. A person whose native tongue is French may have been born in Canada. Either of

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IMMIGRANT HEALTH AND COMMUNITY

the two facts without the other is meaningless. Both must be given in order to complete the racial picture. The new political boundary lines drawn by the Great War will render "confusion worse confounded" if both public and private organizations do not quickly adopt some uniform system of recording both country of birth and racial elements. The following chart suggests a classification which includes both the country of birth and the mother tongue.

A SUGGESTED CLASSIFICATION OF THE FOREIGN-BORN POPULATION BY MOTHER TONGUE AND COUNTRY OF BIRTH

MAIN HEADINGS REPRESENT MOTHER-TONGUE GROUPS. SUBCLASSES SHOW THE COUNTRY OF BIRTH OF PERSONS USING THE GIVEN MOTHER TONGUE. NO COUNTRIES REPRESENTED IN THE UNITED STATES BY LESS THAN 5,000 PERSONS IN 1910 ARE INCLUDED IN SUBCLASSES

<i>Albanian</i>	<i>English and Celtic</i>
<i>Armenian</i>	Ireland
Turkey in Asia	England
<i>Bohemian and Moravian</i>	Canada
Austria	Scotland
Germany	Wales
<i>Bulgarian</i>	Australia
Bulgaria	West Indies
Turkey in Europe	<i>Finnish</i>
<i>Danish</i>	Finland
Denmark	Russia
Germany	<i>Flemish</i>
<i>Dutch and Frisian</i>	Belgium
Netherlands	<i>French</i>
Germany	Canada
<i>Esthonian</i>	France
Russia	Belgium
	Switzerland

DEATH RATES OF THE FOREIGN BORN

<i>German</i>	<i>Serbo-Croatian</i>
Germany	Hungary
Austria	Austria
Russia	Montenegro
Switzerland	
Hungary	<i>Slavic Language</i> (Group
Canada	not specified)
	Austria
<i>Greek</i>	Hungary
Greece	
Turkey in Europe	<i>Slovak</i>
	Hungary
<i>Italian</i>	Austria
Italy	
Austria	<i>Slovenian</i>
Switzerland	Austria
	Hungary
<i>Lettish</i>	
	<i>Spanish</i>
<i>Lithuanian</i>	Mexico
	Spain
<i>Magyar</i>	Cuba
Hungary	
	<i>Swedish</i>
<i>Norwegian</i>	Sweden
	Finland
<i>Polish</i>	
Russia	<i>Syrian and Arabic</i>
Austria	Turkey in Asia
Germany	
	<i>Turkish</i>
<i>Portuguese</i>	
Portugal	<i>Ukrainian (Ruthenian)</i>
Atlantic Islands	Austria
	Russia
<i>Rumanian</i>	
Rumania	<i>Yiddish and Hebrew</i>
Hungary	Russia
	Austria
<i>Russian</i>	Rumania
Russia	Hungary
Austria	England
	Germany

IMMIGRANT HEALTH AND COMMUNITY

It may be hoped that the census of the United States will follow the general principles of this memorandum in their enumeration of "races." Public health departments and other public and private organizations dealing with medical and health work will find it simple and easy to use in their routine recording of individuals, in birth and death returns, in hospital and dispensary records, and in the information gathered regularly about patients by visiting-nursing associations, tuberculosis and philanthropic organizations.

A classification based on mother tongue is, in practice, simpler to utilize for the average nurse, social worker, or clerk, than a classification based on the political country in which the individual was born. It is easy to secure the information from the patient, for he is never uncertain as to what language he spoke, whereas he is likely to give the name of a town or a district as the country of his nativity, just as though an American traveling abroad, and asked his nativity, should reply "Illinois" instead of "The United States of America." Once mother tongue is ascertained, it is necessary in some cases to find out the country from which the patient has come, but a preceding question about mother tongue makes this more certain of ready and correct answer.

The routine collection of information about racial origin, according to the system herein proposed, will be of untold value in connection with all forms of vital statistics. Public and private organizations will profit from it, and it will enable us to pursue many special studies, as well as to interpret routine statistical reports in terms of the important and neglected factor of race.

DEATH RATES OF THE FOREIGN BORN

It has not been our aim in these chapters to present any final conclusions as to race differences in death and disease rates, for the known facts do not warrant such an attempt. It has been our endeavor to point out that those facts which have been collected show, *prima facie*, that certain race differences are of practical significance for the medical and health worker, the health officer, and the administrator; that further continued investigation of the racial factor, and consideration of it in the interpretation of most vital statistics, is a scientific and practical necessity. The need of uniformity in recording racial data is obvious, and a simple method of securing this accuracy and uniformity has been suggested for the consideration of the individuals and organizations who must do the work.

IV

HOUSING VERSUS HEALTH

HOUSING is such a fundamental problem that it requires a more general review than a survey of any single community can give. In the large cities where do we find the immigrants living? Down in the busiest and most dilapidated section, from which the well-to-do part of the population has moved long since. Huddled in the many rooming and boarding houses which the men who emigrate alone establish in every community, jammed into tenements with other families, seeing nothing but the dirty streets, the immigrant must find his life. The ugliest and dreariest, as well as the most unsanitary, portions of city housing are his.

Tenement-house life, as seen by an immigrant at first hand, has been vividly described by Mr. Ravage in his book *An American in the Making*. A new arrival in New York City, he was taken in by a relative till he could gain a foothold for himself.¹

During the day my relative kept up the interesting fiction of an apartment with specialized divisions. . . . I remember how overwhelmed I was with this impressive luxury when I arrived. But between nine and ten o'clock in the evening this imposing structure suddenly crumbled away in the

¹ M. E. Ravage, *An American in the Making*, pp. 72-73.

HOUSING VERSUS HEALTH

most amazing fashion. The apartment suddenly became a camp. The sofas opened up and revealed their true character. The bureau lengthened out shamelessly, careless of its daylight pretensions. Even the washtubs, it turned out, were a miserable sham. The carved dining-room chairs arranged themselves into two rows that faced each other like dancers in a cotillion. So that I began to ask myself whether there was, after all, anything in that whole surprising apartment but beds.

The two young ladies' room was not, I learned, a young ladies' room at all; it was a female dormitory. The sofa in the parlor held four sleepers, of whom I was one. We were ranged broadside, with the rocking-chairs at the foot to insure the proper length. And the floor was by no means exempt. I counted no fewer than nine male inmates in that parlor alone one night. Mrs. Segal with one baby slept on the washtubs, while the rest of the youngsters held the kitchen floor. The pretended children's room was occupied by a man and his family of four, whom he had recently brought over, although he, with ambitions for a camp of his own, did not remain long.

Getting in late after the others had retired was an enterprise requiring all a man's courage and circumspection, for it involved the arousing of an alarmed, overworked, grumbling landlady to unbolt the doors, the exchange in stage whispers of a complicated system of challenges and passwords through the keyhole; the squeezing through cracks in intermediate doors, which were rendered stationary by the presence of beds on both sides; much cautious high-stepping over a vast field of sprawling, unconscious bodies; and, lastly, the gentle but firm compressing and condensing of one's relaxed bedmates in order to make room for oneself. It was on such occasions as these also that one first became aware of how heavy the air was with the reek of food and strong breath and fermenting perspiration, the windows being, of course, hermetically sealed with putty and a species of padding imported from home which was tacked around all real and imaginary cracks.

IMMIGRANT HEALTH AND COMMUNITY

Quite contrary to the prevailing idea that the immigrant deliberately seeks out these regions, he has been driven to them by economic necessity and by the prejudice of the native mind toward him. The immigrant's attitude toward this segregation of his people is brought out by Ravage:¹

I know that the idea prevalent among Americans is that the alien imports his slums with him to the detriment of his adopted country, that the squalor and the misery and the filth of the foreign quarters in the large cities of the United States are characteristic of the native life of the peoples who live in those quarters. But that is an error and a slander. The slums are emphatically not of our making. So far is the immigrant from being accustomed to such living conditions that the first thing that repels him on his arrival in New York is the realization of the dreadful level of life to which his fellows have sunk. And when by sheer use he comes to accept these conditions himself, it is with something of a fatalistic resignation to the idea that such is America.

When the immigrant lands on our shores at some large gate city, he often has no money other than the sum which he must have in his possession before the law permits his entry. Sometimes he does not know a soul on this side of the ocean. He neither speaks nor understands English. He must, then, turn to cheap quarters, and to a region where others live who speak his tongue. These factors, affecting the new arrivals for decades, have built up and overcrowded our Little Italies, Polands, and so forth. Those who come seek cheap quarters among their own races; those who are already here seek not only to increase their incomes by taking boarders and

¹ M. E. Ravage, *An American in the Making*, p. 66.

HOUSING VERSUS HEALTH

roomers, but also to help their fellow countrymen in establishing themselves.

The great desire of some southeastern European immigrants—and in this respect they differ somewhat from the northerners—is to save money at any sacrifice, so that they may some day go back to the land

IMMIGRANTS FIRST GO TO LIVE IN CROWDED DISTRICTS AND OLD HOUSES

of their birth and live in ease. Others, who have left families in Europe, save vigorously, not only to support them at home, but to bring them to this land.

A frequent American attitude toward such saving is expressed in an editorial from the *Boston Transcript* of July 17, 1919. The writer was discussing the return of Italians to Italy with the money which they had saved in the United States:

IMMIGRANT HEALTH AND COMMUNITY

The voluntarily returning laborer or trader usually makes it a point to have laid up \$2,000 before he returns to his native country. . . . And it was neither a very long nor a very difficult matter for him to save \$2,000 in the United States. . . . As the Italian laborer's wages in this country have fully doubled, it would appear that \$5,000 is now as easy for him to get as \$2,000 was formerly.

The long days of back-breaking work, the nights spent in wretched holes, that this amount might be saved, have evidently been forgotten by the author. The object of such strict economy is legitimate; the result is often wretched housing, with consequent ill health for the savers.

The presence of the immigrants in the tenement districts of our cities, forming new Italies, Polands, and Portugals, cannot be accounted for on an economic basis alone. They have been segregated by the intolerance of those who regard themselves as the only real Americans. Real-estate owners, both native and foreign born, testify to this fact. The foreign born feel bitter that they are not allowed to rent or buy houses in the better residence sections of our cities.

Occasionally, by some mischance, a foreign-born family does slip into such a neighborhood. Then the native real-estate owner tells a tale of woe. Near-by native tenants, learning of the invasion by the foreign-born American family, immediately get panicky, conclude that "the neighborhood is running down," and move away to other regions. Then property depreciates. Is it any wonder that the real-estate owner does all he can to keep the foreign born out of the better residence districts? In any city a little investigation will expose the fact that immigrant families

HOUSING VERSUS HEALTH

moving outward from the center of congestion find themselves following fleeing Americans.

Fresno, California, may be mentioned as an illustration. This city of more than fifty thousand population lies in the midst of an extremely prosperous and rapidly developing agricultural district, where raisins and fruit are the most important crops. The foreign residents of Fresno were estimated in 1919 to number twenty thousand or more, one third of the total population. With their children included they would constitute more than one half. In the report on "Fresno Immigration Problems," by the State Commission on Immigration and Housing of California, it is said that 55 per cent of the public-school children have foreign-born fathers. Armenians, Russian-Germans, Italians, Mexicans, Germans, and Japanese form the largest groups; but there are considerable numbers of Danish, Portuguese, Chinese, Swedes, Hindus, and Greeks.

One quarter of the city is notably "American," filled with houses of the characteristically comfortable and attractive California type. The adjoining quarter on the same side of the railroad track contains a number of less prosperous native born and various other nationalities, but it is dominated by the Armenians. Houses in this quarter give less appearance of prosperity, but they are still comfortable. On the other side of the track, separated as it were by a great social gulf, live most of the newer incomers, some, like many of the Russian-Germans, in tiny houses, others in crowded tenements or "barracks."

Lines of social cleavage are sharply drawn about the Armenians, who are probably the largest single

IMMIGRANT HEALTH AND COMMUNITY

group of foreign born in Fresno. They came to California a generation ago and have been successful in farming and in business. Gradually they have moved from the "other side" of the railroad track to the portion of the city which they now occupy. They want contact with native born. Their prosperous members endeavor to buy houses in the American quarter, but cannot do so. A prominent resident in Fresno said that a native-born neighbor of his could have sold his property to an Armenian for 50 per cent above its ordinary value, but he refused to do so, and he would have been socially ostracized by his friends if he had. In the high schools the native-born children are rarely allowed to mingle socially with Armenians.

Race prejudice, language barriers, strange customs and manners, have all had their share in this unnatural shutting away of our foreign-born Americans in the dreary districts of our cities. Wretched and unsanitary housing is not the immigrant's responsibility alone. The native American must bear a large share of the guilt.

Improvement of health and housing depends not so much on details as upon the readiness of people to work together to substitute desirable for undesirable conditions. Lack of mutual knowledge among different race groups strikes a body blow to community spirit and renders successful health work far more difficult.

HOMES AVAILABLE TO THE IMMIGRANT

The quarters which the new arrival finds available to him are, in general, of three types: First, the large old

HOUSING VERSUS HEALTH

houses, once occupied by the better-to-do element of our cities, which have been more or less remodeled to meet the new demands; second, the tenements which have been built especially for the immigrant; and third, the houses erected by industry for their employees.

The first of these provide probably the most wretched living conditions. Built originally as spacious homes for small families, they are ill adapted to remodeling for large numbers of people. They had large rooms, windows for light and ventilation, rambling, connecting spaces, airy hallways, and but few toilets and washing facilities. When these structures are turned into tenements, what happens?

Sometimes practically no alteration is made, and many families must live under conditions suitable for only one. More frequently, changes are instituted. The big airy rooms are divided into many small ones. Thus the lighting and ventilating capacity of the original windows is lost, and dark rooms with no outside ventilation are formed. Toilets are built into the narrowed and darkened hallways, and faucets are put in on each hall floor for the common use of the tenants. Into these patched-up structures crowd the immigrants, accustomed to the outdoors and agricultural life, ignorant of urban sanitation and toilet facilities.

The tenements are, as a rule, a step better than these remodeled houses, although they have insufficient allowance for sunlight and air as well as inadequate toilets and washing conveniences. Only too often model tenements erected for the foreign born come to be occupied by the semiprofessional class, such as

IMMIGRANT HEALTH AND COMMUNITY

clerks, social workers, and teachers, and so do not serve as demonstrations in housing and sanitation for those who are unfamiliar with American conditions.

Houses constructed by industrial concerns for their employees furnish an interesting study. Great impetus has been given to this activity by the housing program pursued by the United States government during the war. Permanent villages were built around the industrial establishments which were likely to endure after the war, and many temporary ones were erected elsewhere. These villages grew out of the imperative war-time demand for stable labor forces. Without decent and adequate housing labor could not be induced to stay long in one place, so millions were spent by the United States government to this one end.

For many years, however, certain industries have felt the great need of decent housing for their employees, and have made attempts to secure it. The houses found in certain isolated mining regions are examples. In some parts of the East whole villages have been developed by the chief local industry. Whitinsville, Massachusetts, is a case in point. The more recent plan is to build houses for employees on easy payments, so that the individual industry does not own the worker body and soul. The kind of houses built, and the number of modern conveniences in them, depend on the degree of enlightenment of the industry, on its size, and somewhat on its location.

PREVALENT TENEMENT CONDITIONS

The preliminary report of the tenement-house survey of New York City, made in 1919 by the Reconstruct-

HOUSING VERSUS HEALTH

tion Commission of the state of New York, depicts prevalent conditions:¹

By the time this work is completed we will have visited 1,700 houses, consisting of about 34,000 apartments, accommodating between 175,000 and 200,000 persons.

In innumerable instances families are crowded together in dark, ill-smelling apartments and are unable to find other quarters. . . . To a great extent vacancies exist in Italian and other foreign districts. There has been practically no immigration during the past few years. During this time a great many of the inhabitants of the Italian sections in the lower and upper East Side went abroad to fight for their country.

Thus it is evident that the immigrants who have once known better quarters than the slums cannot be induced to live in them again. It is in the regions occupied by the newly arrived immigrants that the most miserable tenements are found. . . . It is apparent that one who has become accustomed to the comparatively better conditions in the Bronx and upper Manhattan cannot be induced to return to these portions of the city where the old, dark tenements are in such abominable repair. . . . All of these apartments have interior, dark rooms, but these exist in practically every neighborhood that was investigated by the committee. In a block in the East Forties vacancies existed in houses of a similar type. Very often they were caused by a lack of proper sanitary and toilet facilities. These were situated very often in the yards and were used by a number of families. The rooms in the vacant apartments are dark and in many cases damp. Practically all the houses were in need of repair.

Certain of the conditions that were found to exist in practically every block can be remedied by better management. These include lack of repairs, such as walls without plastering, walls needing painting, dirty halls, courts,

¹ Address of Abram I. Elkus, chairman, before a meeting of the Reconstruction Commission of the state of New York on June 9, 1919.

IMMIGRANT HEALTH AND COMMUNITY

and yards, and, above all, unsanitary conditions brought about through lack of care of toilets.

A study of a block in the East Forties gives some very good examples of conditions difficult to remedy. The thirty-six tenement houses in this block are all old brick houses built before 1901 and showing all the evils of the "old law" tenement construction. The lighting is particularly bad. Of some 1,200 rooms in the block, 600 have indirect lighting—that is, they have no windows opening to the outer air, only the so-called windows opening on to another room. Of the other 600 rooms, only half have windows to the street. The others open on a back yard or on a court. Of course, these 600 dark rooms must be used. In almost every case they are bedrooms. It is evident that at least 600 people and probably a great many more, since at least one, often two, three, and sometimes four people sleep in these dark bedrooms, are compelled to sleep under unsanitary conditions, no matter how well they keep their apartments. There are apartments of three and four rooms, arranged in corridor fashion—that is to say, each succeeding room depending on the last for the exit and entrance. On the plans filed with the Tenement House Department, these rooms would be labeled successively parlor, dining room, living room, with toilet adjoining, and bedroom. Where only the last room is used as a bedroom, proper conditions would exist, but they cannot if, as is invariably the case, the so-called parlor and dining room and often the kitchen are used as sleeping quarters.

The notable work of the California Commission on Immigration and Housing in improving such conditions is discussed later.

BOARDERS IN EVERY THIRD FOREIGN-BORN HOME

The crowded conditions under which the immigrants live were attested beyond dispute by the United

HOUSING VERSUS HEALTH

States Immigration Commission Report in 1909.¹ The commission secured information from more than 17,000 households in industrial localities. Among the households whose heads were native born the average number of persons per sleeping room was 1.92, as contrasted with 2.53 among those whose heads were foreign born. The following table shows the per cent of households of each nativity group which kept boarders or lodgers.

TABLE XVIII
PER CENT OF HOUSEHOLDS KEEPING BOARDERS OR LODGERS BY
GENERAL NATIVITY AND RACE OF HEAD OF HOUSEHOLD ²

NATIVITY OF HEAD OF HOUSEHOLD	PER CENT
Native born.....	9.9
Native born of foreign father.....	10.9
Foreign born.....	32.9
Croatian.....	59.5
Lithuanian.....	57.6
Ruthenian.....	56.9
Magyar.....	53.6
Polish.....	48.4
Slovak.....	36.0
Italian—North.....	34.2
South.....	33.5
German.....	16.2
Canadian, French.....	15.4
Irish.....	14.8
Bohemian and Moravian.....	8.8
Hebrew.....	8.4

Only those nationalities are included in the table of which 500 or more households were studied.

The table brings out the fact that the households

¹ Jenks and Lauck, *The Immigration Problem*, 1913, Table VI, p. 457.

² *Ibid.*, Appendix E, p. 459.

IMMIGRANT HEALTH AND COMMUNITY

which take the greatest number of boarders or roomers are the latest comers from eastern and southeastern Europe. The Croatians, Lithuanians, Ruthenians, Magyars, and Poles show a high percentage. In the tables from which the above extracts were made the Serbians and Rumanians showed extremely high percentages, but they were based on less than a hundred families and so have not an adequate basis for comparison. In the more recent immigration the young men come alone, those with families bringing them over in later years. This is especially true among the Greeks, the Balkan races, and the peoples of Asia Minor. The communal system of living practiced by these men leads to serious overcrowding.

Of the 15,127 households of the foreign born included in the Federal study, 34 per cent had seven or more persons per household, as against 13.8 per cent of the native born of native parents. Nine and one tenth per cent of the foreign born had ten or more per household as against 1.2 per cent of the natives. It is apparent that this congestion among our foreign-born population must work for serious impairment of health.

AMERICAN HOUSING VERSUS IMMIGRANT HEALTH?

What effect on the health of the immigrant have the unsanitary housing conditions to which he must submit in this country? Inadequate washing facilities mean unclean bodies, homes, and clothing. Overcrowding means aggravation of these evils, as well as the rapid spread of contagious diseases, like tuberculosis or diphtheria. Lack of knowledge as to the proper use of toilets leads to their fouling as well as

HOUSING VERSUS HEALTH

the contamination of the entries and halls. Too little fresh air and sunlight brings lack of bodily vigor.

Data secured by the Children's Bureau in its study of infant mortality, in Johnstown, Pennsylvania, present further evidence of the ill health resulting from bad housing.¹

An absolute measure of the importance of each housing defect in a high mortality rate cannot be secured from this study. But it is not without interest to note that in homes where water was piped into the house the infant mortality rate was 117.6 per thousand, as compared with a rate of 197.9 in homes where the water had to be carried in from outdoors. In the homes of 496 live-born babies the infant mortality rate where bathtubs were found was 72.6, while it was more than double, or 164.8, where there were no bathtubs. Desirable as a bathtub and bodily cleanliness may be, this does not prove that the lives of the babies were saved by the presence of the tub or the assumed cleanliness of the persons having them. In a city of Johnstown's low housing standards the tub is an index of a good home, a suitable house from a sanitary standpoint, a fairly comfortable income, and all the favorable conditions that go with such an income.

In homes of one, two, three, or four rooms, or where the number of occupants ranged from 4.42 to 1.58 persons per room, the infant mortality rate was 155, as compared with a rate of but 101.8 in larger homes, where the number ranged from 1.22 to 0.43 persons per room.

The 1910 census returns show that the greatest overcrowding was in ward 15, where the average number of persons per dwelling was 9.9. Wards 16, 11, and 14 came next, with averages of 8.3, 7.7, and 7.2, respectively. The infant mortality rate for these four wards is 190.2, which is over one third more than the rate for the whole city.

¹ Emma Duke, "Infant Mortality, Johnstown, Pennsylvania," *Bulletin No. 9*, Children's Bureau, United States Department of Labor, 1915.

IMMIGRANT HEALTH AND COMMUNITY

The Manchester study, made by the same bureau in 1917, brought out similar points.¹

Conditions in and around alley and rear houses were found by the agents to be almost uniformly bad, and the infant mortality rate for babies in such houses was high. Live-born babies in these houses numbered 123, or 7.9 per cent of the whole number. These babies died at the rate of 227.6 per 1,000, while the death rate among babies in homes with a street frontage was only 159.4.

The infant mortality rate showed a steady increase according to the number of persons per room. It was 123.3 where the average was less than 1; 177.8 where the average was 1 but under 2; and 261.7 where the average was 2 but less than 3.

Such figures as these are convincing evidence of the serious menace which bad housing presents to the immigrant.

One of our health officers has thus explained why American housing is usually *versus* the immigrant's health:²

Congestion, the crowding of large numbers of persons upon a small area and of families into cramped dwelling quarters, favors communication of diseases, uncleanness, and inadequate ventilation. . . . These influences show statistically in infant mortality and the death rates from tuberculosis and other diseases.

TESTIMONY OF HEALTH OFFICERS

The attitude of American health agencies toward the housing problems of the immigrant will be im-

¹ Beatrice Sheets Duncan and Emma Duke, "Infant Mortality, Manchester, New Hampshire, 1917," Children's Bureau, United States Department of Labor.

² J. S. McNutt, *A Manual for Health Officers*, 1915, p. 512

HOUSING VERSUS HEALTH

portant in determining their solution. A series of questionnaires sent to 261 health departments in cities in the United States which had large foreign-born populations brought replies from 142 cities. The problems of housing and home sanitation were giving serious concern to 74 of these health officers—52 per cent of all who answered. In contrast to this the contagious-disease problem, which is usually of such paramount importance to health departments, was spoken of in only 37 questionnaires, or 26 per cent.

Some of the officers claimed that the immigrants deliberately seek out the worst housing locations so that they can annoy the officers of the law by violating all sanitary codes. Asked what problems had been met in his experience as health officer in dealing with the foreign born, one man answered, "Ignorance and willful violation of all health rules." Another writes:

The average Italian . . . lives in colonies in the old tumble-down districts of the city. [They] are clannish, following many of the old native country fashions, and, above all, cannot be made to appreciate the personal and economic value of a general clean-up and stay clean.

For others the immigrant seems to represent a race apart, quite different from all others when it comes to questions of sanitation and housing. One of this group—after referring to the "Dagoes" and "Polacks" in his community—said there was "great need of cleanliness," but that "very little had been accomplished." One reason for this man's failure is apparent in the very tone of the reply. Another claims that "there are no laws of sanitation and living by the average foreign-born family." Another makes the sweeping ac-

IMMIGRANT HEALTH AND COMMUNITY

cusation that the immigrant is unable "to understand what constitutes sanitation." It is not unlikely that the immigrant's inability to understand is here due to the health officer's antagonizing those whom he wished to reach, instead of employing educational methods.

IN PEASANT COUNTRIES BATHING AND WASHING WERE DONE OUT OF DOORS

Some health officers have recognized the need of the foreign born for education in the sanitary care of houses.

Our foreign population is being instructed in sanitation through the Health Department, the District Nursing

HOUSING VERSUS HEALTH

Association, and the school nurse. These branches seem to me to be the best fitted for this work as they have direct access to the homes of the foreigner when called in cases of illness and contagious disease.

Another group whose attitude was investigated



IS IT ANY WONDER IT TAKES TIME TO LEARN TO USE
A BATHTUB?

was the industrial physicians. Of the 80 replies received, there were only 22 who spoke of the importance of housing in relation to the efficiency of the foreign-born employee. Many of these 22 felt

IMMIGRANT HEALTH AND COMMUNITY

that bad housing conditions should be corrected by community action rather than by industrial.

One doctor spoke of trying to get his "people out of basements" as a good housing measure. Another wrote that the "foreign born should not live in clans, but mingle with the native race," a rather interesting remark when one recalls the attitude of the average member of the "native race" toward this question. Still another physician thinks that "the tendency of the foreign born to live in colonies and to patronize in a business and professional way only those speaking their own language . . . are practices that militate against rapid Americanization." This man has evidently not given much thought to the cause of this tendency to colonize. His cure for it is to teach the foreign born the English language. He advocates penalizing industries which employ non-English-speaking workmen, as well as the men themselves.

More thoughtful answers indicated a desire to seek industrial as well as community solutions. One advocates "careful supervision of housing conditions by nurses and doctors." Another suggests: "Provide good housing. Create and foster a community spirit, stimulating initiative." A third writes that his company is "instructing them [the foreign-born workers] in the Building Association plan of purchasing their own homes instead of rooms and tenements." Most of the physicians felt the need of nurses to do educational work in sanitation and hygiene in the homes.

Abram I. Elkus, chairman of the Reconstruction Commission of the state of New York in 1919, summarized in his report the problem of housing our immigrants in New York City. After a discussion of

HOUSING VERSUS HEALTH

the preliminary findings of the tenement-house survey made by this commission, he said, in conclusion:

We must decide on a housing policy. We must look the whole problem straight in the eye. We must find a way out. We have spoken of American standards of living, and look at the kind of homes we give to the newly arrived immigrant. The landlord of one of the houses that had subagencies said to one of our investigators that he would have no trouble in filling his house when immigration had again started. What is the use of talking of Americanization and education if the people of this city are to be forced to live in the homes that are being pictured by our block surveys? It is time that we should look at this matter clearly.

BETTER HOUSING

First, decent buildings, with adequate modern conveniences, should be erected by private interests, communities, or industries. This is not the time to decide who shall do it, but to get it done. The community itself must either control them absolutely or retain sufficient reserve power to insure proper standards of construction and maintenance, both of individual buildings and of entire building schemes in relation to town planning.

There is a great opportunity here for the native born to co-operate with our new Americans in making and executing building plans. Each race coming to our shores brings with it a building experience of its own as well as an appreciation of beauty in architecture. A recent report of the American Red Cross Commission to Italy includes a section devoted to "Housing in Italy," where this point is elaborated:¹

¹ Mildred Chadsey, "Housing in Italy," *Report of the Commission for Tuberculosis, American Red Cross in Italy*, pp. 2, 3.

IMMIGRANT HEALTH AND COMMUNITY

Americans might learn much from Italians, who, through centuries of experience in building and in seeing examples of building for people who live in groups, develop better plans for multiple dwellings than Americans. They might get suggestions for city tenements built about courts that would not present the hideous rear view that makes parts of some cities like New York and Chicago look like wildernesses of back stairs and clotheslines, and would afford a better place for assembling and outdoor work than the street in front of the tenement. . . .

American housing experts who prepare our building and sanitary codes might learn from Italians the value of such sections as the following, taken from the Roman code:

It is forbidden to paint the doors and windows of the building with colors that are out of harmony with the tint of the walls of the building.

The color of the outside of buildings facing public streets must be harmonious and uniform for the entire length of the wall. In case of disagreement on the color to be used, the communal authorities shall decide.

In buildings and in villas having special artistic or historical character, it is forbidden to make alterations which shall threaten in any way their æsthetic value.

Do not such regulations as these, self-imposed by the Italian people, point to their inherent love of beauty in housing and their respect for its preservation? Yet, considering the Italian immigrants as they crowd into our slums, the native born are too apt to lose sight of this significant point. To recognize and utilize such heritages as these would result in mutual respect and increased understanding.

Second in the solution of the housing problem, many foreign born will need education in the use of decent houses, so that they will not be abused. To be successful this education must be undertaken in a

HOUSING VERSUS HEALTH

co-operative spirit. The customs of the group concerned must be understood, their reaction to their new dwellings carefully watched, and the educational process adapted to their particular needs. The whole problem of educating the foreign born in hygiene is so involved with this matter of method that we must return to it toward the end of the book after other elements have been introduced.

Third, the most important and most difficult factor of all is the necessity for changing the point of view of the native American toward this whole question. It must be altered fundamentally. The foreign born must not be regarded as a neighbor to be kept at arm's length, but as a neighbor to be really lived with. Only by human contact can we hope to assimilate our new Americans into our national life. The housing problem involves the most important sanitary and health relationships, but its difficulties largely arise from a combination of economic conditions with social prejudices and misunderstandings. Its solution is impossible on either a philanthropic or a business basis alone, or by any combination of the two, unless a broad foundation of human, neighborly understanding underlies the whole endeavor.

V

SELF-HELP AND HEALTH

It is little realized that immigrants have extensively developed organizations for aid in time of illness which function quite independently of any American agency. Frequently in small communities wherein native Americans must depend upon their individual resources in time of sickness, and wherein publicly organized facilities are inadequate or nonexistent, the foreign born will have well-defined organizations for sickness and death insurance and for medical care.

This capacity for co-operation is an inheritance which most of our foreign born bring with them from Europe. Many of the southeastern Europeans, notably the Italians, have been members of local or village co-operative associations at home, which they continue in this country. Almost all of these associations, although they may be formed for other purposes—social, cultural, or political—include some scheme for sickness and death insurance.

It is well to dwell upon the contrast between native and foreign born in this respect, but we should by no means leap to the conclusion that because of the prevalence of sick and death benefit societies among the foreign born, they are fully protected against the

SELF-HELP AND HEALTH

emergencies of illness. Far from it. We must investigate not only the extent of service rendered by these societies, but also its adequacy and efficiency.

RACIAL BASIS OF BENEFIT SOCIETIES

To secure information in regard to the organizations of the foreign born is difficult. The data presented here have been gleaned between the Atlantic and Pacific coasts through many interviews with foreign-born doctors, doctors and members of fraternal societies, and from various articles and reports, particularly those of the Pennsylvania, Ohio, and Illinois Health Insurance Commissions. It is fragmentary, but it indicates the extent to which the foreign born have organized for protection against sickness.

Benefit societies are found in great numbers and are of much importance among the races of the new immigration — the Slavs, Italians, Magyars, Jews, Greeks, and Portuguese. They are usually racial in origin, founded on common language and heritages. In the United States benefits for illness and death play a significant part in membership. These organizations are such an important factor in the lives of the immigrants that American medical and health agencies should recognize and co-operate with them as far as possible.

The data and the impressions secured by our investigators furnish confirmatory and illustrative material from a considerable number of different communities in various parts of the country. For our purposes we have roughly classified societies among the foreign born which include benefit fea-

IMMIGRANT HEALTH AND COMMUNITY

tures into four groups, according to their chief reason for existence.

FOUR TYPES OF BENEFIT SOCIETIES

One type is based upon national or group consciousness. Of this the "Polish National Alliance" and the Jewish "B'nai B'rith" are examples. A major purpose of these societies is to keep alive the love of the homeland or of the race tradition and to aid in securing freedom from oppression for their fellow nationals in Europe. These societies usually have a large membership and are influential.

A second type might be classed as fraternal organizations, such as the Loyal Order of Moose, the Foresters, or the Fraternal Order of Eagles, some of which are international in influence. We usually think of these as American institutions, but many foreign born belong to them, and there are lodges whose whole membership is foreign born. They are not, however, typical of societies developed by the immigrants themselves for self-aid.

Societies of another type, highly developed among the Poles and Lithuanians, are connected with the churches. Mr. Horak remarks in the report of the Health Insurance Commission of Illinois:

Contrary to the general impressions, relatively few societies are connected with churches or have a definitely religious aspect. The chief exceptions are among the Italians and some of the German societies. It should be said, too, that the Catholic churches without regard to

¹ *Report of the Health Insurance Commission of Illinois, May 1, 1919, p. 524.*

SELF-HELP AND HEALTH

race have benefit organizations within them, but these have found no particular place in this study.

The investigations made by this study in several localities other than Chicago establish the connection between certain racial societies and the church. The Pennsylvania Health Insurance Commission also reports several church organizations as carriers of insurance in that state. Among them might be mentioned the "Lithuanian Roman Catholic Alliance of America," the "South Slovenic Catholic Union," and the "Slavonic Evangelical Union of America." These societies come into being primarily for social purposes and aid in sickness is a secondary function. There may be several such societies in a single parish.

The fourth group, reaching intimately immigrants from eastern and southeastern Europe—comprises the small local societies to be found wherever the foreign born have settled. The locals of trade-unions might be included in this group, although they give little aid in sickness. These societies have two general reasons for existence, the proximity in this country of individuals who speak the same language and have the same racial heritage, and their common origin in some village or town in Europe. These societies range in size from 25 members to 700 or 800; and as many as 300 societies among a single race may be found in some of our large cities. One hundred such Italian societies are reported to exist in Boston.

GENERAL CHARACTER OF SOCIETIES

Most of these organizations were formed for social and cultural purposes. The insurance feature, how-

IMMIGRANT HEALTH AND COMMUNITY

ever, has become very important with increased familiarity with the exigencies of life in the United States. Through these organizations both death and sickness benefits are extended to members.

Many employ a doctor to examine all applicants for membership, and all members applying for sick benefits. Others, however, do not bother with a special doctor. The member may choose his own physician and the society will pay a set amount for each examination or visit of that doctor. In some societies medical services are included, not only for members, but for their families as well. In others the doctors employed by the society give free service to society members only, but charge reduced rates to families.

Sick benefits are subject to several limitations in most societies, such as that one week of illness must elapse before benefits are paid, and that membership in the society for a year is required before application for sick benefit is allowed. A two weeks' membership usually secures the death benefit. In some societies the dues are graduated according to age, increasing in amount with the years.

Most of these societies admit men only to membership, some admit men and women, and some women only. The relative scarcity of women members reflects the attitude of the men of the new immigration toward their womenfolk. Among the Italians and Poles there are numerous women's societies organized chiefly for intellectual or cultural purposes. Benefits are attached, but they are of secondary importance.

The number of societies to which an individual may belong is limited only by the size of his pocket-book. An Italian, for example, may belong to one

SELF-HELP AND HEALTH

national organization and several district or village societies in which he may have a right to membership. Dues must be paid to each, and, in case of illness or death, benefits are derived from all, as brought out in an investigation of health conditions in Ohio:¹

Many of the miners, perhaps the foreigners more than others, carried sickness insurance in several organizations, so that the statement was frequently made that a man while sick might draw more money in sick benefits collected than he did while well and at work.

Conditions similar to this were found by this study in the mining regions of northern Minnesota and Michigan.

Societies differ considerably according to the races represented in the membership. Only the church and the small local organizations will be considered in examining these racial differences. The Poles, Italians, Jews, and Greeks offer the most interesting variations. Much of the data on the Poles and Italians was secured by interviews with families in one of our large Eastern cities. Many of these families could not speak English. More than fifty-five Polish and about forty Italian families were visited and a chat of an hour or so held with each. These interviews have given some interesting sidelights on societies which could hardly have been secured in any other way.

CHURCH, KEYSTONE OF POLISH SOCIETIES

Among the Poles it was estimated that 70 to 80 per cent of the men belonged to at least one society, and

¹ "The Health of Ohio Coal Miners," *Ohio Health Insurance and Old Age Pension Commission Report*, 1919, p. 875.

IMMIGRANT HEALTH AND COMMUNITY

that 50 per cent of the women have organizations of their own. Many of the Poles who were not members of a society in the United States were those who considered their stay here too transient to warrant membership.

An analysis of the fifty-five family interviews showed that whereas 36 per cent of the men were members of church societies, only 19 per cent of the women were so affiliated. On the other hand, the tables were almost reversed on the question of life-insurance policies carried by commercial companies—the Metropolitan and Prudential seemed popular among these Poles. Here 36 per cent of the women were insured, 27 per cent of the men, and 48 per cent of the children. This last large figure is of interest in connection with the findings of the Ohio Health Insurance Commission. In reading the following it will be remembered that large numbers of the coal miners in Ohio are of Slavic descent:¹ “The usual forms of industrial insurance were everywhere present in the mining districts, through which children, in particular, are covered for funeral benefits.” The charge for a \$100 policy was usually 10 cents per week for a child, 25 cents per week for an adult.

These findings indicate a larger proportion of Polish wage earners helped by benefit societies than do those of the Pennsylvania Health Commission report for wage earners in general. The latter found so many restrictions of age, standing in the society, kind of illness, that it concluded that “This type of health insurance . . . reaches comparatively few

¹ “The Health of Ohio Coal Miners,” *Ohio Health Insurance and Old Age Pension Commission Report*, 1919, p. 375.

SELF-HELP AND HEALTH

in the wage-earning group." The table from the Illinois Health Commission's report, which is quoted later, also shows a much smaller proportion of each race in benefit societies than do the Ohio and Pennsylvania studies.

Polish societies are nearly always connected with the Catholic Church. They exist by reason of close proximity in the United States of people who speak the same language and have the same ardent love for the homeland. Their function is pre-eminently social and nationalistic. Secondarily, however, they aim to aid members and their families in time of illness or death.

The sick benefits paid by church societies average from \$5 to \$7 a week for twelve weeks. A funeral benefit is always included. The services of a doctor appointed by the society are usually available to members in time of illness, although some societies pay \$1 or \$2 a visit for the member's own physician. The men's dues vary from 35 to 50 cents a month, depending, of course, on the extent of sick and death benefits offered. Among the women's societies the dues range from 25 to 35 cents a month, and the sick benefits rarely exceed \$5 a week.

ITALIANS FROM SAME VILLAGE UNITE

Contrasting in many respects with these Polish societies are the Italian. Instead of the church, the keystone of their organization is common origin in a certain village in Italy. Many mutual-aid societies are continuations of similar organizations in Italy, where each little town has its own association for

IMMIGRANT HEALTH AND COMMUNITY

co-operative undertakings. In Genoa, for instance, there is a socialistic industrial society with five thousand members which is running its own industries. Members from this city naturally band together in the United States for self-aid.

Thus it is frequently found that the essential requirement for membership in an Italian society is residence or birth in a particular village or district in Italy. As many of these associations will be found in any colony as there are villages represented. In Boston, as already mentioned, more than one hundred of these societies are to be found, and it is claimed that there are three hundred in Philadelphia. They are usually named after the patron saints of the home villages: "San Domenico," "Santa Brumitto," or "Santa Pepeica." Women's societies are not nearly so numerous as they are among the Poles, and those that do exist are chiefly for intellectual purposes.

Among the men's societies, the sick benefits are practically the same in amount as among the Poles—\$6 to \$7 a week—but the period of payment is a little longer, thirteen to fourteen weeks. One society was found which paid \$10 a week benefit for four weeks. Medical care by the society doctor is commonly given to all members free, and to their families at one half the price usually charged. One society was found which, for an extra charge of a dollar a year a member, extends free medical service to the family. Death benefits of \$50 to \$200 are universal. The monthly dues range from 60 to 75 cents.

The idea that a "society" exists to provide cash or medical benefits is so deeply ingrained in the immigrant's mind that he finds it hard to understand or-

SELF-HELP AND HEALTH

ganization for any other purpose. The following incident came to light during an interview with an Italian family:

Two years ago they joined the Red Cross by paying \$1 and were told that whenever they needed help to apply to them. They did this when the husband was taken sick, but were given no financial help.

Suspicion and dislike of the Red Cross resulted.

NATIONALISTIC INTERESTS OF JEWS

There is little difference between the Italian societies and those among the Jews. The national, or Zionist, movement plays an important part in the aims of many Jewish organizations, and most of their societies are open to both men and women. The lodges, however, are large, as many of them are branches of state and national organizations, and they are based on neither village life nor the church.

In some, sick benefits are paid by the central organization out of dues paid into the central treasury by each local. The dues commonly required to give the \$6 or \$7 a week sick benefit and medical care for members are \$1.25 a month for single men and \$1.55 for married. Membership in the benefit systems is left to choice except in a few organizations. Most people belong to the societies, however, for the sake of the benefits attached.

HOSPITAL CARE AMONG THE GREEKS

The Greek societies are formed almost entirely of men, and they, like the Italians, base their member-

IMMIGRANT HEALTH AND COMMUNITY

ships on former village connections in Greece. According to a Greek physician interviewed in a metropolis of the East:

There are more organizations than anything else among the Greeks. Every group of ten to twelve people from the same village start a society here, as a branch of a society there or as a matter of patriotism. Their principal object is to raise money to send home for some public improvement: a school, a church, or some undertaking by the society in Greece.

Comparatively few of these have sick or death benefits attached. Those that have benefits make an interesting contrast with the racial societies already considered. Hospital care is practically ignored among the Poles, Italians, and Jews. Greek societies, however, employ a doctor on contract, who cares for ill members in some hospital where expenses are paid by the society. This frequent use of the hospital by the Greeks is a significant thing when taken in connection with the communal fashion in which the men of the Greek immigration live. It would seem to be a direct outgrowth of the inadequate facilities for nursing afforded by the communal boarding house.

FIRM FINANCIAL BASIS OF THE PORTUGUESE

Among the Portuguese and Czecho-Slovaks the dues and benefits, both for sickness and death, seem to be somewhat higher than among other races. For instance, in one Portuguese society in California the dues were found to be \$26.50 a year, while the sick benefits varied from \$5 to \$15 a week. Says one doctor on that coast:

SELF-HELP AND HEALTH

Due to this high premium, the societies have a firm financial basis and are one of the few examples of workers' mutuals which have always been able to meet their obligations. As the worker usually belongs to a group of lodges, they furnish quite an adequate sum in case of his sickness. Membership is open to all nationalities, but, due to the difficulty of differences in language, it is usually restricted in practice to the people of one nationality.

Medical aid in time of illness is not always provided by these Portuguese societies.

BENEFIT SOCIETIES IN CHICAGO

A number of the points brought out in the investigations carried on by this study are corroborated in the study of foreign benefit societies in Chicago in 1918 by Mr. Horak, which is included in the Illinois Health Insurance Commission's report. In securing his data, he found the same difficulties in Chicago that this study found in other parts of the United States. Mr. Horak's report presents the best picture thus far published of the sick-benefit societies of any American community.¹

New societies are all the while being formed; many of the old ones disappear because of lack of success in their endeavors or because their members affiliate with other organizations or move away or because these societies tend strongly to become locals of national fraternal orders. Under the circumstances it has been necessary to secure the names of independent societies from other sources—priests and clergymen, political leaders, newspaper men, social settlements, saloonkeepers, undertakers, and the officers of societies themselves. As a result of inquiries

¹ *Report of the Health Insurance Commission of Illinois, May 1, 1919, pp. 523-524.*

IMMIGRANT HEALTH AND COMMUNITY

at all available sources the number of independent foreign societies in Chicago, exclusive of athletic clubs, building and loan associations, entertainment clubs, and singing societies, is estimated at about 600. . . . Some of these devote their attention to educational, political, or social affairs exclusively. Others, and especially many of those among the Jews, are primarily charitable organizations. . . . It is estimated that there are something more than 300 independent foreign societies in Chicago which make more or less extensive and definite provision for meeting the problems connected with sickness, accident, and death. The investigation has been limited to these. Detailed information with reference to the provision made and its administration has been secured from 161 of the 313 found. In so far as possible, those studied have been selected so as to be typical with reference to race, size, and nature of the benefits provided.

The essential part of the following table is taken from Mr. Horak's report. There have been added the number of foreign born in each of the seven largest racial groups in Chicago, and the ratio of the membership in the societies listed to these totals.

In looking at the estimated number of societies for each race we find the largest number among the Czecho-Slovaks and Italians, together representing more than 50 per cent of all the societies. German and Lithuanian represent about a quarter of the total number. Only a certain proportion of the estimated societies were studied, and the membership of these is listed, amounting to a total of 21,024 members for all races. The census figures for 1910 for the larger races are listed as a basis for showing the per cent of society membership in each race. The highest per cent of membership in benefit societies is found for the Greeks, Magyars, Italians, Lithuanians, and

SELF-HELP AND HEALTH

TABLE XIX

INDEPENDENT FOREIGN BENEFIT SOCIETIES IN CHICAGO ¹

	TOTAL POPULATION, 1910 ²	NUMBER OF SOCIETIES STUDIED	PER CENT BELONGING TO SOCIETIES	ESTIMATED SOCIETIES	NUMBERS STUDIED	NUMBER OF THOSE STUDIED PROVIDING EACH SPECIFIED KIND OF BENEFIT				
						Death	Funeral	Sickness and Accident	Hospital	Medical
Croatian.....		170		5	3	3	1	3	1	2
Croatian-Czech.....		140		1	1	1	1	1		
Czecho-Slovak.....	59,354 ³	2,872	4.8	90	57	40	39	14		
German.....	171,681	2,302	1.3	44	18	17	12	14		1
Greek.....	6,742	1,565	23.2	14	9	8	8	6	8	4
Italian.....	45,554	3,559	7.8	80	33	25	16	28		11
Jewish.....	68,771	801	1.2	14	4	3	2	2		
Lithuanian.....	20,273	1,588	7.8	80	8	8	5	2		
Lithuanian and Polish.....		206		2	2	2	2	2		
Magyar.....	9,507	1,596	16.8	6	6	5	3	4		
Polish.....	126,059	2,810	2.2	3	2		1	1		
Russian.....		100		1	1	1		1		
Scandinavian.....	99,513	2,384	2.4	11	7	6	6	0		1
Serbian.....		80		1	1	1	1	1		
Slovak.....		100		3	2	2	1	1		
Slovenian.....		110		2	1	1	1	1		
Miscellaneous.....		631		6	6	2	3	1		
					11	125	97	94	9	19
Per Cent.....						77.6	60.2	58.4	5.6	11.8

¹ Report of the Health Insurance Commission of Illinois, May 1, 1919, p. 524, Table I.

² Thirteenth Census, 1910, vol. 1, p. 989—only for races having over 5,000 in Chicago.

³ Bohemian and Slovak.

Czecho-Slovaks. The Jews, Germans, Poles, and Scandinavians are at the low end of the range. The Poles have only three benefit societies listed; because so many of the Polish societies are connected with

IMMIGRANT HEALTH AND COMMUNITY

the church they were not included in Mr. Horak's study.

BENEFIT SOCIETIES TRANSITORY

The increase in Chicago of Greeks, Hungarians, and Italians has been very large in the last three decades. This table indicates that benefit societies exist among the more recent immigrants. It is fair to say that in general the races which have been in Chicago longest have the lowest, and the comparatively new races the highest, representation in these small independent benefit societies. This fact suggests that they have a transitory existence and serve a purpose in the early period of adjustment to this country.

Further evidence of the mortality of these societies was presented by Mr. Horak in his table of the approximate dates when 155 of them were started.¹

TABLE XX

PERIODS IN WHICH 155 FOREIGN BENEFIT SOCIETIES WERE
FOUNDED

Before 1890.....	18
1890-1895.....	5
1895-1900.....	17
1900-1905.....	27
1905-1910.....	33
1910-1915.....	41
1915.....	19
Total.....	155

Ninety-three of the societies, or 60 per cent, have been founded since 1905. Mr. Horak says that this recent growth of the majority

¹ *Report of the Health Insurance Commission of Illinois*, p. 530.

SELF-HELP AND HEALTH

. . . does not assist in determining how many have ceased to be independent foreign societies because they decayed or died or because they were absorbed by the fraternal orders. Under the circumstances one must only rely upon the personal knowledge of those informed. One of these is authority for the statement that of 125 societies in existence twenty-five years ago in a certain district only 12 remain to-day.

Various causes make for the short existence of these small local societies. It is probably safe to say that they serve a considerable proportion of immigrants who have not been long in this country; but they do not exist as permanent health agencies.

INADEQUATE AS HEALTH AGENCIES

Table XIX brings out the fact that 77.6 per cent of the societies studied paid death, and 60.2 per cent funeral, benefits, 58.4 per cent a sickness and accident benefit, and only 11.8 per cent a medical benefit. The amount paid for death benefit ranged from \$15 to \$250, and was of course intended to meet the cost of funeral expenses, leaving nothing for the remaining family. The sickness benefits showed a range similar to that found in other parts of the country: the minimum was \$2.50 a week; the maximum, in only one case, was \$15; the great majority were \$5 or less.

When these amounts, as in most cases, must be turned over to the family budget, there is little chance that proper medical care can be secured also. This would be insured only in the few cases where it was specifically provided for, largely among the Greeks and Italians. Too often service of this sort

IMMIGRANT HEALTH AND COMMUNITY

is vitiated by the character and extent of medical aid provided.

Testimony as to this is plentiful and points all in one direction. The attitude of the members of these associations toward the physicians employed by them under contract is significant. One Italian said that although his society furnishes a doctor free of charge to him and half price to his family, they never call him—do not like him at all. Said another, "My husband belonged to two societies, but left them, as they were too much *camorista*—that is, too full of grafters." In general the society doctors are neither highly respected nor are they fully used by members.

Numerous interviews with foreign-born and native physicians have brought out richly the attitudes of both the members and the doctors:

When these organizations were first started they were of very high type and of great benefit to Hungarians, but they are fast deteriorating. When they were first organized they had as medical advisers very efficient men; but now a doctor is sometimes not chosen because of any great skill, and a man with good practice has no time for such work.

These doctors are not chosen for any superiority in their profession, but because they are popular with or related to the officers of the organization. As a consequence many times very inferior men hold these positions.

They seem to have the idea that if a doctor comes for nothing or very little, he is no good. They think that any good doctor charges large prices.

An Italian doctor stated that some of his colleagues liked to have an income assured, but "do not care too much about giving care."

SELF-HELP AND HEALTH

They are often retired doctors or doctors who have not made a success in their practice. They are looked down upon by the other doctors in the profession.

Among the Jews the testimony is similar:

The people have little respect for these doctors. They are usually young doctors who accept the position for the purpose of becoming acquainted with the members of the community. I have been asked several times to accept such a position, but have always refused because I felt that the work was degrading. The Jews have little esteem for these doctors. . . . The lodge doctors are chiefly young men just entering the profession or else rather elderly men. Another reason for this lack of confidence in the lodge doctor is the fact that he is a "brother" and consequently too familiar a person to command much respect, for the Jews seem to admire aloofness.

A Portuguese doctor on the Pacific coast stated that the societies there

. . . had found it impossible to get the good doctors at the prices they could pay. The result has been that either they have attracted the poorer class of doctors or those who have come recently to the community.

Evidence of this sort could be multiplied indefinitely. Sufficient has been given, however, to indicate that the medical service secured by these societies is of a low grade. There are some first-class and highly respected physicians in lodge or society practice, but the great majority do not fall into this category.

The burden of the evidence presented in this chapter brings out a number of reasons why the small local or church benefit societies are very much lim-

IMMIGRANT HEALTH AND COMMUNITY

ited as health agencies. So far as can be ascertained, they are of a transitory character, reaching a limited number of immigrants. The benefit too often provides funeral flowers when it might have gone for the medical care which would have prevented the necessity for flowers. When it is designated for sickness it too often fails to gain its end, either because it is inadequate in amount or because the type of doctor provided is unacceptable to the patient. Last of all, the small benefit societies are often on an unsound actuarial basis and are thus doomed to failure or excessive handicap in competition with the larger societies or commercial insurance companies. From these facts it is apparent that they can play no large or influential part in medical care of the immigrant.

ADVANTAGE IN FRIENDLY ASSISTANCE

If the preponderance of the evidence is not in favor of the small benefit society, some of its advantages must not be overlooked. Its required medical examination often affords an initiation into American health practices and standards that might not otherwise be accomplished for some time. It certainly tends to introduce the minimum standard of health and hygiene which prevails in this country. Furthermore, it accustoms the newcomer to a voluntary health-insurance plan. This particular plan might prove unsound, but the habit of depending on some form of insurance would be established.

In addition, it is fair to assume that belonging to a benefit society made up of friends and fellow countrymen, gives to many of its members a sense of

SELF-HELP AND HEALTH

assurance and security which the stranger too often lacks. If the mutual-benefit society can bridge the first period of uncertainty and adjustment it will not be a wholly negligible quantity. Its tangible accomplishments are not always apparent, but the friendly offices it performs in times of trouble have an influence in adapting the foreign born to American ways of doing things.

VI

IMMIGRANT BACKGROUNDS

SOME health officers declare that immigrants love to live in dirt. A housing inspector is said once to have complained that immigrants stored coal in the bathtubs when they happened to be in a tenement with "modern conveniences." This story was probably true somewhere and sometime. But it has been told many times and almost everywhere. Some health workers say immigrants are suspicious, set in their ways, if not stubborn. Many declare them to be densely ignorant of hygiene and unwilling to use facilities for medical care or health service, even when such are offered.

Stories of this kind about the immigrant have been multiplied, but after all discounts are made there remains a kernel of truth in the complaint that the immigrant frequently increases the problem of sanitation, that he and his family do not respond to suggestions so quickly or so completely as the American health worker would like.

Our task is not to distribute praise or blame. It is to state facts, to understand conditions, and then determine, if we can, how conditions can be made more as we wish them. We can hardly know conditions, and we can never comprehend the reasons for them, unless we know the immigrants as well as their

IMMIGRANT BACKGROUNDS

circumstances. The beginning of such knowledge is a familiarity with the characteristics of the chief racial or national groups, and particularly the conditions to which most of them were accustomed before they came to the United States.

PEASANT ORIGINS

The bulk of our immigrants from southern and eastern Europe, except the Jews, are from agricultural districts. This includes the Italians, Poles, Lithuanians, Russians, Slovaks, and Slavic peoples from southern Austria and around the Adriatic Sea. The European agriculturalist does not dwell upon an isolated farm like the American farmer. He is a peasant, by which we mean one closely attached to the soil. He lives in a peasant community, which is a rather compact village, surrounded by the fields to which the peasants go regularly from the villages to work.

There is an active communal life. The individual is first and foremost a social being. There is strong emphasis upon the custom of conformity to the group and upon the habit of participation in the group life. This is in strong contrast to the American farmer, who was originally a pioneer and retains many of his early characteristics. Even in well-settled sections of this country conditions as well as traditions emphasize the individual rather than the group.

Very different are the circumstances of the peasant in central or southern Italy, or Sicily, from which most of our two million Italian immigrants come:

In his home village [says Mr. Sartorio] the Italian slept with his family crowded in one room. That did not hurt

IMMIGRANT HEALTH AND COMMUNITY

him or his family, for they did not live in the room, as they are compelled to do here by the bitter climate; they just slept there for a few hours. During the short, cool Italian nights only were they inside. Life was spent working, eating, and resting in the open air. The sturdy peasant in Italy ate the fruits of his *orto*, drank the wine of his vineyard, wore the wool of his sheep. No one paid attention, except when he went to church on Sunday, to the way in which he was dressed, and he was not very particular how infrequently he shaved. Early in the morning he called out to his friends across the street as he went to the field. No one was disturbed by it. People were up early in the village. He sang as he crossed the village going to work and coming back; the *stornello* of his friend answered his song. He walked in the middle of the street as everybody else did, and did not spit on the sidewalk, for the obvious reason that there was none.¹

Take Professor Fairchild's description of the life which most of our 110,000 Greek immigrants left behind them:

Life in Greece is essentially an outdoor life. It does not take the form of athletics to nearly the same extent as in England and in America. . . . But the Greek loves to sit out in the open air. In fine weather the public squares of the cities are closely dotted with tables belonging to the neighboring coffee houses. . . . To-day, as well as in ancient times, one of the most pronounced features of the Greek character is a sectionalism, a clan-nishness, an inability to take the point of view of one's neighbor, which has extended beyond the tribal limits to the domain of personal relations and individual character, making it very difficult for Greeks to unite in any common enterprise.²

¹ Enrico C. Sartorio, *Social and Religious Life of Italians in America*, p. 20.

² Henry Pratt Fairchild, *Greek Immigration to the United States*, pp. 10, 36.

IMMIGRANT BACKGROUNDS

The primitive character of agriculture among the Polish peasants is illustrated in the following letters. A Polish immigrant had written home from the United States, describing some American agricultural machinery which he had purchased. One of his family wrote in reply:

Now as to the machines which you bought and which are so expensive, don't they know scythes and sickles there? With these tools you can do much during the summer.¹

A father, writing shortly after his boy's departure for America, inquires:

And now, dear son, I ask you, where did you put the ax? Write where you put it, so we shall not have to search for it.²

The picture of that family waiting from one to three months to be told where the ax was, instead of looking for it, may well linger in the memory.

Miss Balch says of the Croatsians:

A Croatian house of the poorer sort is often very pretty, with its steep shingled roof and whitewashed or stuccoed sides. Frequently there is no chimney. . . . In poorer houses there may be simply a fire of twigs and branches on the floor and a baby wrapped in rags lying in the ashes. The family sleeps probably in one room, occasionally on straw covered with the curious Croatian blankets which are almost as shaggy as the original sheep, and woven in bright, angular patterns.

The windows are apt to be small. We heard of people being burned up because they could not get out through the windows when the house was on fire and the doorway

¹ Thomas and Znaniecki, *The Polish Peasant in Europe and America*, vol. i, p. 368.

² *Ibid.*, vol. ii, p. 50.

IMMIGRANT HEALTH AND COMMUNITY

cut off. But this defect is not confined to Croatia. It was among the Slovaks that a priest told us that he preached against windows "so small that it made an eclipse of the sun if a hen flew in," a figure of speech suggestive in more ways than one. . . .

The cattle are often accommodated under the same roof with the family, either on the same level, only separated by a partition, or underneath in a sort of basement stall.¹

The enormous contrast between such home conditions and the immigrant's new surroundings in New York, Chicago, or any other large city, is obvious. The contrast with conditions in a smaller American city like Fall River, Wilkesbarre, or Pueblo is hardly less sharp. Not all our immigrants, even in recent years, are peasants, nor do all enter cities. The great bulk of first arrivals, however, do go to the cities. The people they know from their own country or their own village live there, and they follow the trail of their friends.

One important group from which we draw immigrants, the Jews, has been accustomed for centuries to city dwelling or at least to occupations characteristic of urban life. Jews, however, come to America from small towns as well as from large cities; Mr. Ravage shows us the contrast between New York City and the Rumanian village of his boyhood.²

This remarkable country, so newly discovered for us, was infinitely more wonderful than it had appeared from first reports, and infinitely more puzzling. . . . It was regrettable that we had learned this only after Couza had gone, or we might have asked him to explain how it was managed. We might also have been told in an authorita-

¹ Emily Balch, *Our Slavic Fellow Citizens*, p. 164.

² M. E. Ravage, *An American in the Making*, pp. 29-30.

IMMIGRANT BACKGROUNDS

tive way whether it was true that in New York the railways ran over the roofs of houses, that the dwellings were so large that one of them was sufficient to house an entire town in Rumania, that all the food was sold in sealed metal packages, that the water came up into people's homes without having to be carried, and that no one, even a shoemaker, went to the temple on Saturdays without wearing a stovepipe hat.

The important point for us is to discover what differences between the immigrant's conditions here and abroad have a real bearing upon his health in this country, and so upon American policies and methods of medical or health work. Consideration of these conditions discloses seven points of importance.

PUBLIC VERSUS PRIVATE HEALTH ADMINISTRATION

Although some continental countries have a well-developed system of public health administration in their cities, the people in the villages do not come in contact with it. Hygiene is determined either by personal decision or by custom. The only public control in health matters experienced by the peasant is the regulation of matters of birth, sickness, water and milk supply, by family or district custom.

"In the city," said the little boy in the story, "you get your milk from a cart, but in the country it squirts from a cow." The peasant was familiar with the immediate sources of milk supply in cow or goat. The sanitary supervision and control of the milk supply thus remained with the individual or the family and did not become a matter of public health administration. Also the disposal of refuse was wholly a family matter. Garbage might be fed to the pigs.

IMMIGRANT HEALTH AND COMMUNITY



IN EUROPE GARBAGE AND WASTE WERE BURNED OR FED TO
THE ANIMALS

Refuse might be thrown out or burned. If, however, he throws an armful of rubbish out of the fourth-story window of a city tenement he is in trouble. Street-cleaning departments in some large cities have

IMMIGRANT BACKGROUNDS



IN AMERICA DISPOSAL OF REFUSE IS A PUBLIC FUNCTION

spent thousands of dollars in posters and placards to teach immigrants how to dispose of garbage, how to use the garbage can, when to put it out, where it will be collected, where to keep it when not by the curbstone.

IMMIGRANT HEALTH AND COMMUNITY

When the immigrant is suddenly transferred to a city in which such matters as housing, water supply, milk supply, contagious disease, the disposal of garbage and refuse are dealt with at long range by government agencies through housing inspectors, milk inspectors, food inspectors, school nurses, he can hardly be expected to understand. The change would be difficult for anyone. When the immigrant does not know the language, when no one explains the contrasts and their meaning, how should he comprehend them?

We must understand these contrasts if we are to appreciate the difficulties faced by the health officer, the visiting nurse, and the social worker in dealing with the health problems of the immigrants in our cities. We must also recognize the difficulties which the immigrant faces. Once we attain such a double understanding we can deal with the problem of education in an effective way. It is not by antagonism nor by the weight of the Big Stick, but by explanation of whys and wherefores in terms he will comprehend, and by enlisting his co-operation and that of leaders in whom he has confidence, that we help the immigrant to get the knowledge which life in a large city requires.

UNFAMILIARITY WITH MEDICAL RESOURCES

In many cases the immigrant comes from a small community, isolated from modern medical resources, to a city which has many more advantages. Even a small American city has more doctors in proportion to population than the place which the average immigrant left. In many of the backward districts of Eu-

IMMIGRANT BACKGROUNDS

rope, from which hundreds of thousands of our immigrants have come, there is only one doctor to every 2,000 or even 5,000 of the population, whereas in the United States as a whole there is one doctor to every 700 persons, and even in very small communities the ratio is rarely less than one to 1,200.¹ The immigrant has not been accustomed to use doctors as freely as has the native American.

This is also true in the matter of hospital service. To the peasant the hospital was a distant and unfamiliar institution. It was the resort in extreme emergency. People who went there generally died. The immigrant does not consider that perhaps they died because they waited too long before going to the hospital. The visiting-nurse association, the numerous societies for the prevention of different diseases—tuberculosis, cancer, infant mortality—were quite unknown to the immigrant at home.

NEW RELATIONS TO GOVERNMENT IN THIS COUNTRY

Certain groups of immigrants lived under oppressive governments before coming to the United States. The Poles, whether in Germany, Austria, or Russia, were under a government which they felt was trying to denationalize them. They bitterly resented the efforts of the government to crush out their mother tongue as well as other conditions imposed upon them.

Their attitude toward local as well as national government after they come to the United States is

¹ According to the 1918 American Medical Directory there were about 150,000 physicians in the United States, whose estimated population was about 105,000,000.

IMMIGRANT HEALTH AND COMMUNITY

affected by this previous experience. The Pole has heard of America as a land of freedom, and after he comes here he is likely to note how much less the government interferes with his daily concerns than was usual in his native land. Yet his attitude toward government agents, the policeman, or the health inspector, or the nurse, may be colored by suspicion merely because of his former attitude toward the government of Poland and his incomprehension of the nature and workings of this government.

The Slovaks of Hungary had to live under the rule of the Magyars, and like the Poles felt that an oppressive hand was endeavoring to stifle their language and culture. Such, in greater or less degree, was the situation of practically all the southern Slavic peoples of Austria-Hungary. In a slightly different way the oppressive and corrupt government under which the Armenians and Syrians lived in Turkey is likely to determine their attitude toward government and local agents of government in this country. The Jews, in some instances, have emigrated from similar conditions.

Suspicion or undue and unthinking subservience is the usual result of such a previous experience. The health officer, in his plans for reducing disease, or the nurses or social workers who enter the homes of the immigrants without understanding their backgrounds, can hardly deal adequately with them and their problems.

CHANGED RELATION BETWEEN SOCIAL CLASSES

Distinctions between social classes on the basis of wealth, birth, or education are more rigid in the

IMMIGRANT BACKGROUNDS

countries from which most of our immigrants have come, than they are in the United States. A well-trained American nurse once visited a Polish home to teach the mother something about the care and food for her baby. She reported that the mother seemed suspicious and unwilling to learn. Later the mother said, in substance, to a Polish-speaking visitor:

I do not know who sent that woman to my house. She must be one of the educated people and she must have done something wrong or she would not be going around this way instead of living with her own class and taking life easy as they do.

The Polish woman could not understand social class except as a status into which a person was born, or at least in which a person's position was fixed for life. She could not understand why a woman, evidently belonging to what would be called a superior class, should spend her time in the homes of inferiors.

Generally speaking, the American, as such, has prestige among immigrants. A person who looks, speaks, and acts like an American, as the immigrant conceives an American to be, will sometimes win his way despite ignorance of the immigrant's language. On the other hand, a person of the same race sometimes fails, despite familiarity with the language and national customs. The explanation is found in the peasant's suspicion of social class.

These considerations help determine the kind of health worker who will be most effective among different groups of immigrants. They apply with much more force to certain groups of immigrants than to

IMMIGRANT HEALTH AND COMMUNITY

others, notably to Poles and most of the Slavic groups, somewhat less to the Italians, much less to the Jews.

TRANSITION FROM AGRICULTURE TO INDUSTRY

Within a few weeks the immigrant workman may pass from a quiet, agricultural community to the roar and motion of a steel mill or a stockyard. It has been more than once pointed out that an economic loss is involved when a worker who is skilled in an intensive, though in some respects primitive, agriculture, goes into a factory, mill, or mine, where his former experience counts as nothing, and where he must begin again as an unskilled laborer.

From the health standpoint this transition involves certain hazards, both of accident and of illness. The average peasant has been accustomed to slow motions. He has dealt with materials and processes which involved little risk of accident or of disease. He has not been used to machinery. His new job may necessitate quick motions, there may be poison in the materials to be handled, danger in the processes to be performed. Recent writers on industrial medicine have dwelt upon these contrasts. Let us appreciate the suddenness of the transition, the lack of preparation for it on the part of the immigrant, and the risks to health which are therefore involved.

no disorientation
explosive

PHYSIOLOGICAL STRAIN DUE TO CHANGE IN ENVIRONMENT

The sudden changes and severe winters of New England, New York, or Minnesota are a violent contrast

IMMIGRANT BACKGROUNDS

to the warm climate of Sicily. Italians who make this transition have a considerable readjustment to make. Races from northern Europe find a less, but still a considerable, change in range of temperature and humidity.

Sometimes change in climate may be beneficial. People from the North take a trip to Florida in win-

THE IMMIGRANTS LIVED, WORKED, AND PLAYED OUT OF DOORS IN EUROPE

ter, and people from South Carolina go to Massachusetts during the spring. When, however, the individual makes the transition without those comforts and safeguards enjoyed by the well-to-do American visitor to Palm Beach or to the North Shore, health may suffer instead of being benefited. Many peoples from different parts of Europe experience change in

IMMIGRANT HEALTH AND COMMUNITY

climate upon coming to this country. This is generally accompanied by change from an outdoor to an indoor life. Important changes in diet may also be caused by the migration. Altogether, the change in climate, in food, and in time spent out of doors must frequently produce physiological stress upon the individual

What the influence of such stress may be upon death rates, birth rates, and disease rates is unknown. It is difficult to separate these from other factors. It has been suggested by some writers that the processes of natural selection are accelerated by such a transition, and that individuals not sufficiently resistant to the new physical environment in this country will be more or less rapidly weeded out. Such a biological process, if it exists, may be far-reaching in determining the numbers, vigor, and prosperity of the present and the next immigrant generations.

UNFAMILIARITY OF LANGUAGE

The barrier of language between many groups of immigrants and the native-born American presents difficulties in all social relations as well as in medical and health work. Mutual difficulty of comprehension is one thing. A sense of isolation on the part of the immigrant is another. A sense of superiority on the part of the American is still a third. Difference in language too easily emphasizes all of these.

The segregation of immigrants of one race in the same part of a city or town, largely caused by their dependence on their mother tongue, of course accentuates certain of these difficulties. The learning of

IMMIGRANT BACKGROUNDS

English is made less easy. Group customs familiar abroad and fitted to conditions abroad are maintained or strengthened in the American colony, even though the conditions of American life render such customs unsuitable. Moreover, if he lives in a "colony" of his own people, the immigrant has less contact with his American environment and less daily opportunity for learning about it. It has already been indicated that the responsibility for the formation of immigrant colonies rests partly upon Americans.

Viewing the Old World traditions and customs, we find seven points of contrast with American conditions that complicate the health problem. (1) Private regulation of health matters at home ill prepares him to co-operate with public health administration. (2) Previous isolation from medical resources prevents his seeking those available in America. (3) Oppressive government at home has prejudiced him against public authority. (4) Rigid distinctions between social classes in Europe make him suspicious of friendly help from apparent "superiors." (5) Sudden transition from agricultural to industrial life involves health hazards, as do (6) marked changes in climate, diet, and time spent in the open air. (7) Ignorance of our language fosters misunderstanding.

We have reviewed the contrasts between the immigrant's tradition and experience abroad and the complex conditions of the United States. These contrasts affect all phases of life, industry, education, recreation, the home, and last but not least, the individual and the public health. It is essential that native Americans understand these contrasts. We must learn something about the circumstances from

IMMIGRANT HEALTH AND COMMUNITY

which the immigrant has come, as well as about the conditions which he faces here. We must know the backgrounds and the foregrounds, and fit them together to make a complete picture of the immigrant as a human being and a fellow citizen.

Knowledge of immigrant heritages and of the immigrant's environment in America is the foundation for any impersonal, unprejudiced study of the immigrant and for successful dealing with his problems of health and disease. Neither a program of health nor a program of Americanization as a whole can rest securely upon any other foundation.

VII

IMMIGRANT RESOURCES FOR MEDICAL CARE

THE immigrant's usual background, habits, and living conditions must be held in mind when we consider his answer to the question, "What to do when sick?" The answer to this question is serious enough for the native-American wage earner, and yet the American family is likely to be fairly well acquainted with the physicians and the hospitals of the community and probably knows at least one physician in the intimate relation of family doctor. The problem of the American family is not so much unfamiliarity with resources as financial limitation.

With the immigrant it is quite different. His answer to the question, "What to do when sick?" depends not so much upon the medical resources which are available in the community as upon what he knows about them.

The readiness with which medical resources become known to the average immigrant is largely determined by three factors: (a) their localization; (b) their advertising; (c) their contacts with the immigrant through people or organizations of his own race. These three points should be considered in all plans to make American medical resources more readily available and more thoroughly utilized by the foreign born.

IMMIGRANT HEALTH AND COMMUNITY

Resources for the care of illness become known in somewhat the following order to the average immigrant coming from a small community to a city in the United States:

Home and Neighborhood

The home remedy or "wise" woman

The midwife

The drug store

Doctors

The advertising doctor, medical institute, or quack

The private physician

The lodge doctor

Organized American Agencies

The nurse

The hospital

The dispensary

HOME AND NEIGHBORHOOD

It seems the part of wisdom to the immigrant to try resources that are near at hand and that do not cost much, before turning to others. In minor illnesses the immigrant, like the native born, appeals to the home remedy. Traditionally potent herbs and concoctions familiar in the home village play a large part in the family dosing of many immigrant adults and their children.

The uneducated mind of the immigrant turns also, with a confidence at which the sophisticated American can only wonder, to the neighbor or friend of reputed wisdom. The grandmother of one's own or more often of a neighbor's family, the witchwoman, known in the old country, and now in her little circle here, as one having power to heal or to prevent healing—

RESOURCES FOR MEDICAL CARE

these have frequently been mentioned to visitors investigating the health habits and resources of immigrant families. The more or less experienced woman is put to a specialized use in midwifery. This practice is prevalent among immigrants and requires discussion in a later chapter. When a visiting nurse finds a family curiously slow to respond to her well-meant advice it is probable that the wise friend or witchwoman has already furnished them with advice of the opposite nature.

THE DRUG STORE

The local drug store, the place where most patent medicines are purchased, is an important center of medical advice. There are several reasons for this. Usually the local druggist or some one in his employ speaks the immigrant's language, and if there is a large colony of any one mother-tongue group there are certain to be several drug stores where the language is spoken. The drug store is localized and therefore readily becomes known to the immigrant. We must appreciate also that the pharmacist is regarded by many immigrants as a man of learning. The drug store is anxious to co-operate with the immigrant and the immigrant's local organizations.

The result is not always what we would wish, but the drug store must be reckoned with. A young pharmacist, born abroad but trained in America, told his plans for his first venture as a druggist:

"I can speak Russian, Polish, Yiddish, and German. I know that neighborhood [in which the drug store was to open] and the people there. I just bought out the old

IMMIGRANT HEALTH AND COMMUNITY

man who has been running that store. He has not made good, but I am sure I can. He only speaks English. He has had a Yiddish-speaking clerk, but the clerk was more interested in himself than in the business."

"Do you know some doctors in the neighborhood so that they will send you their prescriptions?"

"I know one doctor, but the people will know me better than they know the doctors before long."

• Drug stores are important from the medical standpoint because it is to them rather than to the doctor that the immigrant first turns. New arrivals and people who have not had occasion to use a doctor since their arrival frequently turn to the druggist for advice about doctors. Local doctors are, therefore, the friends of the druggist and his store is a meeting place both for social acquaintances who chat and for business competitors who keep an eye on one another.

An Italian store in Providence, a Greek in Lowell, a Finnish in Maynard, a Hungarian in Bridgeport all seem to be rather effective health centers for the surrounding colonies of their people. The Hungarian druggist here mentioned describes his business thus:

Hungarians do not use as many patent medicines as Americans. They make more of their own brews from herbs in the fields in Hungary. Hence I carry a large stock of these. The Hungarians use hardly any pills. The medicines they use are mostly in liquid form. The druggist will not sell any poisonous drugs whatever except on doctor's orders. This habit was acquired in Hungary, where the law forbids such sales. Long before the anti-narcotic law was passed he did this.

In regard to suppression of the patent-medicine evil, he feels that only responsible and trained druggists should be allowed to sell drugs. In Hungary only one drug store

RESOURCES FOR MEDICAL CARE

was licensed for every five thousand population. In the United States grocery and dry-goods stores carry drugs. In hands of the ignorant drugs are sold to the ignorant.

For myself, I do not care. But it isn't fair to American druggists to let these stores and mail-order houses sell these things, and then not be responsible. The druggist is responsible. Why, they sell paregorics by the bottleful and stomach-trouble cures! Maybe for an alkaline stomach they sell bicarbonate of soda and for an acid stomach some acid. Here in this country a druggist does everything: telephones, soda fountains, information bureau, doctor. In Hungary he is a skilled pharmacist.

When a woman comes to me for something for her child, if she says, "Summer complaint," I tell her to go to a doctor right away. That is too serious to try anything with. I usually refer such requests to a doctor, though I do prescribe for minor ailments. People do not like to bother with a doctor. He is a nuisance. He says not to eat this nor give the baby beans, or something else. Some medicine which the druggist says will cure you surely is so much simpler.

In the large cities the local druggist plays a similar part amid immigrant colonies, but families do not depend upon him so heavily as in smaller places and he feels the competition of American drug stores on the main streets more keenly.

PRIVATE PHYSICIANS

The line between legally recognized medical practice and drug-store practice in dealing with disease is not a sharp one, as the preceding quotation illustrates. The "drug-store man" goes as far as he can, sometimes as far as he dares, according to his knowledge and his conscience, in prescribing remedies for

IMMIGRANT HEALTH AND COMMUNITY

the symptoms of which his customer or "patient" tells him.

Perhaps after home and neighborly resources the advertising doctor is best known to the immigrant. He may not be localized in the immigrants' section, but his advertisements reach them through the foreign-language newspapers. His methods and advertised medicines are discussed later in this report.

Both native and foreign-born physicians carry on reputable private practice in immigrant neighborhoods, and to these the immigrant has reasonably easy access. One of them may even be retained by his lodge to care for sick members.

According to American medical ethics the doctor does not advertise except by a simple shingle outside his office. So, except as their offices are in his neighborhood, the immigrant can with difficulty ascertain the names of reputable native-born physicians. Doctors of many foreign races follow their native custom of inserting professional cards in the newspapers of the language, and this is a substantial assistance to the immigrant. Such advertising doctors are in no sense the notorious quacks who exploit the immigrant so extensively.

Interviews with private physicians, either foreign born or of foreign parentage, whose practice was largely among immigrant families, were obtained in New York, Chicago, and other large cities to the number of more than one hundred and fifty. Interviews were also held with native private physicians who had special contact with the foreign born. Studies of medical work in rural districts and in

RESOURCES FOR MEDICAL CARE

particular fields were made. The first aim of this investigation was to discover how far different immigrant races develop their own professional men and to what extent this has solved their special health problems.

INADEQUATE SUPPLY OF IMMIGRANT DOCTORS

It was possible to estimate the number of foreign doctors in three ways. The American Medical Directory gives lists of doctors graduated from foreign medical schools, as stated for each community. Lists of doctors include those with foreign names. Interviews were had with at least two leading doctors of each nationality in each community. From these sources approximate figures were deduced. There are in Chicago not less than 300,000 Poles, with not more than 100 Polish doctors. On the other hand, the Jewish population in Chicago, which is probably about the same as the Polish, includes from 1,200 to 1,500 doctors. The 80,000 Lithuanians are said to have 12 doctors. The Bohemians, numbering perhaps 100,000, have about 40 doctors. The Greeks have between 15 and 20 doctors of their own race, for a population of 20,000. The Italians in a population of 150,000 have about 70 doctors.

The marked contrast between the Jews and all other groups is noticeable. The Jews have developed a large number of physicians, who, however, do not confine their practice to Jewish people. The Greeks in Chicago have a larger number of doctors in proportion to population than any other group except the Jews. The proportion of doctors in these races

IMMIGRANT HEALTH AND COMMUNITY

holds true, roughly speaking, for other cities. The proportion of Italian doctors to Italian population in Chicago (43 per 100,000) approximates the corresponding figures for Boston (33 for 80,000 or 41 per 100,000), and for Providence, Rhode Island (27 doctors in estimated 60,000 population, 45 per 100,000). The proportion of Polish doctors to Polish population in both Boston and Chicago is between 25 and 30 per 100,000.

In small communities there will often be found no doctors of the race to which a considerable number of the population belongs. Maynard, Massachusetts, has a population of about 2,000 Finns in a total population of 6,000, yet not one of the five doctors of the town is Finnish. In Duluth, Minnesota, with an estimated population of about 5,000 Finns, there are only 2 Finnish doctors out of 109 doctors of all nationalities. The Ohio Health Insurance Commission reported that the physicians in the mining communities of Ohio and Illinois are almost entirely native born, despite a very large number of foreign born in the population.

Not a few immigrant groups in large cities are now encouraging their young men to enter professions, such as law and medicine, and often assist them to get a start. A Polish physician, who occupied an important hospital post in one of our large cities, and who had been in this country for thirty years, told how he had watched the growth of Polish immigration and the increasing efforts in several large centers of Polish population to develop young professional men. As we see, the results of these efforts are only beginning to appear. The unusually large proportion of

RESOURCES FOR MEDICAL CARE

Jewish physicians is perhaps accounted for by the Jewish aptitude for intellectual work, the high estimation in which the professional man is held by the Jewish people, and the economic success and mutual helpfulness of the group.

We can hardly overestimate the contribution made to American life by those immigrants who, despite all obstacles, have won their way to success in a profession which requires so long a training and yields such slow financial returns as medicine. Some of our foreign-trained or foreign-born physicians have been notable leaders in the American medical profession, and many young men of foreign parentage are now winning their way to well-deserved distinction.

On the other hand, it must be recognized that the medical service for the mass of immigrants must be from average rather than exceptional men.

Moreover, no immigrant group, apparently, confines itself, or wishes to confine itself, to doctors of its own race. This may be partly for the reason already pointed out, that there are not enough doctors of the recent immigrant groups, except perhaps among the Jews, to provide all the medical service needed; but the testimony of the Polish, Italian, Russian, Hungarian, and Greek doctors is all to the effect that their practice is among native born as well as among people of their own race. The foreign doctor has the great advantage of understanding the language and customs of his people. On the other hand, the native-born doctor may, and often does, carry prestige because he is native born. Except among the Jews, very few foreign doctors have been

IMMIGRANT HEALTH AND COMMUNITY

found whose practice was entirely among immigrants of one race.

DIFFICULTIES OF IMMIGRANT PRACTICE

Statements such as the following, revealing the special difficulties that medical care of the foreign born entail, are typical of interviews with doctors of several races widely scattered throughout the country.

A Hungarian doctor in Connecticut states:

There is no such thing as a family doctor among the Hungarians. In a case of pneumonia they might have any number of doctors even at the time of the crisis. A man will say to me, "We do not want you any more." "Why not? What is the trouble?" I would get the answer, "Oh, my wife she get worse. You no good. We get another doctor." At first this discouraged me, but I have gotten used to it now. I have seen six or seven doctors meet at a bed unexpectedly.

A Polish doctor from Chicago gives similar testimony:

Among the poorer people it is common for three or four doctors to be called in on the same case. One doctor is called, prescribes, and leaves the medicine. After the patient has taken two or three doses without noticing any benefit he calls another doctor without telling the first. A doctor who wishes to know how a patient is getting along and makes a call without being sent for must do this at his own expense.

An Italian doctor from New York said:

Italians almost always call an Italian doctor because of the mutual sympathy and common language. The Italians are very fond of their families and will spend every cent

RESOURCES FOR MEDICAL CARE

to care for a member if ill. They are not satisfied with the American doctors because they make a short visit, prescribe, and leave. This leaves the family in much doubt and accounts somewhat for their calling in another doctor if there isn't a marked improvement in a few hours. The Italian doctors tell the family what the malady is, and explain to them all about it, and this is what they expect. But the Italians are very excitable and when a child gets sick they run off for the nearest doctor, regardless of nationality. They always pay cash and as a consequence they are inclined to call various doctors at different illnesses, just as they patronize different stores. Most of the Italians in this section are from the north of Italy and many of them knew one another in the old country. I was known in Europe by most of these people, and when I came to New York I had a big practice almost immediately.

From these instances it is evident that the problem is not merely to cure the patient. It is to make him and his family believe that he is cured or is going to be cured. Furthermore, the doctor has to compete with other resources for curing disease—the drug store, the quack, the wise woman, the hospital, and the dispensary. Often he needs to be a psychologist and a financier as well as a medical man, if he is to cure, convince, and make a living at the same time.

To make a financial success of practice among the foreign born a man must work hard. His fees are not large compared with those charged by physicians and surgeons among the well-to-do. He is a general practitioner and he can derive relatively little income from surgical operations. In order to attend enough cases to make a living he must hurry through them all. If he has not enough cases to keep him busy he must nevertheless act as if he were busy, lest his prestige be diminished.

IMMIGRANT HEALTH AND COMMUNITY

Careful medical work generally calls for a thorough physical examination of each patient; some history of the patient's disease, previous illnesses, and family health; a stethoscope should certainly be used in examination; and some laboratory tests ought almost always to be made. As a matter of fact, such physical examinations, history-taking, and laboratory tests are almost unknown in this class of medical practice. If the doctor is trained to such procedures—which is not always the case—he has not time, or he fears the patient will not understand, or would be unwilling to submit. Also, the doctor must work with poor equipment. Some of these physicians can afford a microscope, and a few appear to have one. They are called upon to treat all kinds of disease, but their equipment of instruments and appliances for diagnosis and for treatment is usually very limited compared to that provided in a well-equipped hospital or dispensary or in the private office of a physician in good circumstances.

These limitations are not, as a rule, the fault of the individual physician. In some cases they are due to inadequate training at the low-grade medical schools formerly tolerated in this country. In many instances, however, they simply result, first, from financial inability to provide more than a low minimum of professional equipment, and, second, from lack of time or opportunity to utilize fully the knowledge and facilities which the physician does possess. Laboratory tests (except those provided by health departments for contagious diseases) are practically beyond the reach of the average foreign-born patient. The fees charged by private laboratories are often

RESOURCES FOR MEDICAL CARE

more than the fee the doctor himself would get for an ordinary visit. .

The physician practicing among the foreign born rarely has a position in a hospital or dispensary. In New York City, where hospitals and dispensaries have been developed as fully or more fully than anywhere else in this country, an investigation made by Dr. E. H. Lewinski-Corwin showed that 51 per cent of the registered physicians had no connection with either. In communities where hospital and dispensary service are less developed than in New York the proportion is undoubtedly smaller. The 50 per cent or more of the medical profession who have no institutional connection includes most of the men in general practice in the poorer sections of the community, and so those who serve the foreign born.

Lack of time and lack of training on the doctor's part are more responsible for this deprivation than prejudice on the part of the hospitals and dispensaries, although the latter is not infrequently a factor. The private physician fears that he may lose his patients and he avoids the use of hospitals and more particularly of dispensaries, through which free consultation with a specialist might be had for his patient.

Let it not be thought that this review of medical practice among the foreign born has ignored the devoted, efficient, and unselfish service rendered by innumerable physicians, often when struggling under very difficult conditions. It would be easy to multiply such examples, and to illustrate the splendid ideals of the medical profession and their finely developed application by men of all races working

IMMIGRANT HEALTH AND COMMUNITY

among both rich and poor. But our part has been to indicate some limitations and problems of medical practice among the foreign born in order to aid, if possible, the fuller realization of these ideals and their application on a more inclusive scale of community service.

More remote than the home and neighborhood resource, the midwife, and the doctor, legitimate or quack, is the distinctively American health agency. The nurse, the hospital, the dispensary, and other forms of organized health service are usually unfamiliar to the newly arrived immigrant. He is not accustomed to turn automatically to any of them. If they are to be successful in their work, ways must be worked out whereby they meet him more than halfway. How to achieve this will be discussed after we have taken up more fully some immigrant health customs which present special difficulties.

Part III

SPECIAL IMMIGRANT PROBLEMS

VIII

THE MEDICAL QUACK

WHEN the immigrant falls seriously sick the first hope of a cure is apt to come to him through the promises of a medical quack. This would-be friend reaches the immigrant in his home through the foreign-language paper and, like most things in this new land, is taken on faith.

In nearly all foreign-language newspapers medical advertisements appear. A few of them are the legitimate professional business cards of ethical foreign-born doctors, announcing their presence to people of their own race. Most of them, however, are inserted by quack doctors, quack companies, chemical companies or laboratories, for a purely commercial purpose, which is to amass fortunes by cheating the immigrant.

To be sure, "quackery and the love of being quacked are in human nature as weeds are in our own fields," and quacks conduct a certain amount of business among our native-born and English-speaking people. But their activities among native born have been checked somewhat by exposure of their methods in certain papers and magazines, and they have turned their attention to the fertile field of our immigrant population. Quack advertising in American newspapers has decreased, while in the foreign-

IMMIGRANT HEALTH AND COMMUNITY

language newspapers it has enormously increased, during the past five years. Let us remember that to the immigrant newspapers are to some extent organs of authority as they are not to the native born. Abroad, it is not so easy for private individuals to perpetrate frauds upon fellow citizens through the medium of the press. A Russian doctor in Chicago writes:¹

Foreigners, as a rule, do not differentiate between the regular physician (in America) who does not advertise and the advertising quack. Quite the opposite; they look upon the advertising charlatans with considerably greater respect than upon the regular physician, as in their childish simplicity they look upon everything printed in the newspapers as absolute truth. They do not understand even that an advertisement is written and paid for by the advertiser, and innocently think it is the newspaper that praises those physicians because they are so good.

If the immigrants could follow in imagination the stream of their money as it flows past the newspaper publishers, past the men who furnish the drugs, past the quacks themselves in their comfortable automobiles and mansions, seeing them all grow rich as they grow poor, they would read with harder hearts and more active brains the glowing promises of the "doctors."

We must inquire what really happens when the sick or ailing immigrant reads in his own language, in the newspaper of his own people, in his adopted land (remember it is the promised land of his ideals), the advertisement of the quack. How much is he

¹ Henry R. Krasnow, M.D., *The Foreigner a Prey of Medical Quacks*, Illinois Medical Journal, 32: 342 Nov. 1917.

THE MEDICAL QUACK

helped or injured, how much is he doped and bled by the quack doctor, the fraud office, the worthless or harmful nostrum bought at the drug store or ordered by mail?

UNSCRUPULOUS METHODS

Twelve hundred and thirty-three of the newspapers published in the United States are printed in some language other than English. Think of it! In 1828 only eight hundred newspapers all counted were published in our country. And now the American foreign-language press is half again as great in numbers and probably has as many readers as there were then people in the whole United States.

In August, 1918, we wrote to about a hundred foreign-language newspapers asking: (1) for copies of their latest issues, (2) for their advertising rates for medical advertisements, and (3) whether they published an almanac or calendar. The price of the papers was inclosed.

Most of the newspapers sent the desired copies, and a few other foreign-language papers were bought, adding to the number examined. About twenty-six returned advertising rates. A few replied that they published no medical advertisements. One publisher asked to see copy before quoting prices, as he did not accept all medical advertisements. Eight almanacs and calendars were secured.

All the medical advertisements were clipped from these foreign-language newspapers. They amounted to over seven hundred and were printed in eighteen languages. This is a cross section of the medical advertisements in more than one hundred leading

IMMIGRANT HEALTH AND COMMUNITY

foreign-language newspapers at an arbitrarily selected moment during the summer of 1918. The advertisements are varied in form. Some are short and matter-of-fact; some are long, but easy reading for an unsuspecting person; some are in display type; some have a supposed portrait of the famous doctor advertiser; some are cleverly illustrated in other ways. Almost all have one characteristic in common—a claim of superhuman power over human disease. In many cases a cure is guaranteed. More frequently a cure is implied in such a manner that the ordinary reader gets the idea that it is promised. But clever wording will usually save the wicked advertiser from legal punishment and leaves the patient a helpless victim.

The field covered by these quacks is almost as extensive as the medical dictionary. A list of one hundred and fifty different disorders or diseases was made from a few of the advertisements that were translated, and this could have been greatly extended. We learn that if we do what we are told we will be cured of asthma or anæmia; backache or bad luck; colds, cancer, constipation, or catarrh; dyspepsia or drunkenness; eczema or ear trouble; fistula or fatigue; gout or general weakness; headaches or hernia; indigestion, infectious diseases, or impurity of the blood; liver complaint, lung trouble, or “any long-lasting chronic disease”; nervousness or night emissions; overwork; “special acute troubles,” “special chronic troubles”; just “troubles,” “too much food,” teething, trachoma, tape worm; vertigo or yellow fever. Of course syphilis and gonorrhœa appear with great frequency, usually under one or

THE MEDICAL QUACK

more of their numerous camouflages; and so do female disorders, such as dysmenorrhoea, infertility, or too frequent fertility.

Further analyzing these advertisements, we found 232 different medical advertisers. Seventy-one of these inserted merely a doctor's business card, which, according to European custom, is perfectly proper. Of the 232, 156 advertised once, 32 twice, and 43 three or more times. Of the 44 men or companies whose advertisements were found three or more times in our cross-section study:

19 advertised 3 times				2 advertised 9 times			
8	"	4	"	2	"	10	"
2	"	5	"	4	"	12	"
3	"	6	"	1	"	17	"
2	"	7	"	1	"	19	"

The amount of this advertising shows the scope of the business. It is no small or insecure concern that carries advertisements in a number of papers simultaneously or in several languages.

The 160 nonethical advertisers were operating from 55 different cities and towns located in 18 different states, and in one city of Canada. The part of the country covered stretches from New England to Washington, D. C., and westward to California. None east of the Mississippi were located south of Washington. We are not justified, by this, in thinking that our South is free from quacks, but rather that there are not many foreign born and foreign-language papers there. Certain business locations appeared to be profitable: New York City held 73 of all the advertisers; Boston, 25; Chicago, 23; Pittsburgh, 15; San Francisco, 12; and Detroit, 9.

IMMIGRANT HEALTH AND COMMUNITY

The nationalities represented in the study were eighteen in number:

Arabic	German	Polish
Armenian	Greek	Portuguese
Bohemian	Hungarian	Russian
Croatian	Italian	Slovak
Finnish	Lithuanian	Swedish
French	Norwegian	Yiddish

There is some ground for believing that the newer immigrants more easily fall prey to the wiles of the quack. This surmise was strengthened when 104 advertisements were carefully translated and characterized by race.

TABLE XXI
NUMBER AND CHARACTERIZATION OF QUACK ADVERTISEMENTS
TRANSLATED FROM FOREIGN-LANGUAGE NEWSPAPERS

LANGUAGE	NUMBER	CHARACTERIZATION
French.....	3	Rather brief; not very glaring.
Swedish.....	2	Rather mild.
German.....	22	About half brief; none lurid. Over half of the German advertisers confine themselves to German-language newspapers.
Italian.....	29	All sorts; brief, lengthy, extravagant.
Croatian.....	4	Not lurid, but certainly appealing.
Greek.....	3	Most of them long and extravagant.
Hungarian...	23	All rather long, and designed to scare.
Polish.....	7	Not very long; sometimes coarse.
Yiddish.....	2	Extravagant offers.
Russian.....	3	Appealing to simple type of mind.
Finnish.....	6	Uncharacterized.
	104	

From this it would seem that the French, Swedes, and Germans do not favor the most lurid advertisers. The Germans are unique in that more than half of the advertisers among them do not advertise in other

THE MEDICAL QUACK

languages. In all, there were 147 advertisements in the Italian language, more than in any other. They include all sorts, brief and lengthy, mild and lurid. The Greek, Hungarian, Polish, Russian, and Yiddish groups supply many examples of the long, extravagant, lurid advertisement. It is well to mention that although the Greeks seem to belong to this group, two Greek papers, the *Star* and the *Atlantis*, are among the very few foreign-language newspapers to refuse all fake medical advertisements.

In order to ascertain what some of these quacks did, as well as what they said in the newspapers, letters were written to fifty-one different advertisers, as if in response to their advertisement. These letters were written in Italian, Polish, German, and English, most of them under assumed names.

We had prompt replies from thirty-four. Usually the reply was a typewritten form letter, sometimes inclosing a questionnaire, testimonials, and an addressed return envelope. In one case (Health Specialist Sproule) a stamped, addressed envelope was inclosed. From one ("Apothecary") a postal card quoting the price of a medicinal soap which he had advertised was the only reply. In a few cases letters like the following were received.

SAN FRANCISCO, Nov. 19, 1918.

DOMENECO PACE:

DEAR SIR,—Your letter is at hand. Send me \$10 (ten dollars) now for your medicine for your sickness and I will send it to you.

Yours, etc.,

J. F. GIBBON, M.D.,
1944 Cal. Street.

IMMIGRANT HEALTH AND COMMUNITY

Now Doctor Gibbon's advertisement had promised to cure a variety of diseases, and "Domeneco Pace," in whose name we had written, had given no symptoms. Our letter merely stated that he had been sick a long time, and spent much money for doctors, and wanted to know the cost of a cure.

Eight of the thirty-four advertisers sent under separate cover various kinds of booklets and pamphlets. The most elaborate of these was from Doctor Williams's Cancer Sanitarium. It has fifty-six illustrations, many of them horrible views of cancer of various kinds and stages. Pictures of conditions before treatment are contrasted with the cured patient after treatment. It is interesting to find that some quacks who advertise in three to five different languages in the newspapers send their letters and circulars in English only, or in English and one other language.

Two weeks after these first replies, follow-up letters began to come. Sixteen of the thirty-four advertisers sent these, varying in number from one to eight. More circulars came also. The Plapao Laboratory sent with the follow-up letters the greatest amount of printed matter, including one large sixteen-page publication, *The Disillusionist*, and another large one of eight pages, *The Progressionist*. The Dr. R. H. Kline Company sent the greatest number of letters. One came from them each month. So persistent a follow-up system seems remarkable, in the case of this company, because, as they tell us that we can buy their remedies "at all leading drug stores," they do not know whether we are buying them or not. A number of these com-

THE MEDICAL QUACK

panies possess an elaborate system, with dates, numbers, or letters stamped or written on the return envelopes. In this way they can check up the result of the original advertisement.

Despite their personal wording, many of the type-written letters are crude in form, so that anyone with the least experience would know them to be circulars. Yet many immigrants have had no such experience at all and are impressed by them as personal communications.

The quack has other methods of advertising besides the newspaper and personal correspondence. Circulars, leaflets, dodgers, or cards are often distributed from house to house through the localities inhabited by immigrants. Sometimes the advertisement takes the form of a convenient little notebook and diary, printed in English and one or two other languages. There is reason to believe, however, that in recent years quacks have placed more dependence on foreign-language newspapers and less upon the distribution of circulars.

Another method of getting the public confidence is described in a report from the New York State Bureau of Industries and Immigration (1914):¹

A museum is fitted up in a prominent section of the city with a gorgeous display of physiological exhibits. Upon entrance to the lobby, where the exhibits are open and free to all men, you are approached by a person who gives you literature which is so framed as to make one suspect, judging from the symptoms and signs which are described in the circular, that one has symptoms of some awful

¹ *Fourth Annual Report, New York State Bureau of Industries and Immigration, 1914, pp. 257-258.*

IMMIGRANT HEALTH AND COMMUNITY

plague and every other conceivable disease; thus is one induced to consult a specialist in charge of the museum, who has his office in the building. . . .

Not only are the successful quack advertisers clever business men, they also appear to be expert psychologists. They know how to compel people to give attention.

The medical advertisements which form the basis of our study range in size from a few lines to a whole page. A small proportion are short, almost as brief as a business card. The following is an example:

DR. JOSEPH BIER

WOMAN SPECIALIST

INVENTOR OF LAUDANT ANTISEPTIC POWDER

FOR WOMEN

302 West 72d Street

Hours 11-1

On the other hand, a medical advertisement may be 723 words, filling a whole page of 147 inches with large display type and an illustration. Such is the "Partoglory" advertisement printed in Polish in the *Ameryka-Echo*.

This advertisement illustrates a showy and expensive type, probably from a very prosperous company. It is cleverly and attractively written by a professional advertisement writer. The cost of one insertion we estimated at \$123.48, according to the quoted advertising rates of the paper. The largest portion of the advertisement, like so many, is given over to a discussion of current events, of which the following is only a part:

THE MEDICAL QUACK

September 9, 1918

AMERYKA-ECHO

(At left picture of American soldier)

THE ALLIES ARE MOVING FORWARD

The English have taken Bapaume—Noyon has been taken by the French. The Americans have captured Juvigny. After a hot battle, in which all the armies of the Allies showed unheard-of courage and bravery, three main territories were taken from the Kaiser. Our American soldiers under the leadership of

GENERAL PERSHING

have shown the enemy that they possess the true spirit of battle. . . . Until the end we Poles are heart and soul for President Wilson, with whose help we have had opportunity to regain Freedom and Polish Territory. But at the same time we must remember that our health plays an important part in our lives. Without health nothing can be reached and yet there are a great many people among us who disregard their health. . . . Nervousness is an illness which is spreading at the present time.

Because of this, learned people are working with energy to find a sure cure for nervousness. After several years of study, practice, and knowledge there was discovered at last a successful elixir for the nerves

PARTOGLORY

which is used by thousands of people with unusual results. Partoglory was discovered by a renowned chemist and pharmacist, Michael Partosa . . . etc.

The inventor of Partoglory invented also excellent candy, "Partola," which is very efficient in all troubles of the stomach. If your stomach is not in order, if you suffer from constipation, if you have a headache, if you suffer from lack of appetite, eruptions on your face and body, there is no better medi-

IMMIGRANT HEALTH AND COMMUNITY

cine than Partosa's Partola. Take three candies before going to bed and the very next day you will be normal and healthy. Specifications and testimonies are contained in the advertisement.

It is common to find an appeal on the basis of nationality. The following is typical:

DR. COLHOEUR—SUCCESSOR TO DR. WILLIAM ALDEN
717 Liberty Avenue, Pittsburgh, Pa.

Fellow-Citizens: Look for help there where you can find it, which will bring you out on the right path. This is the only doctor from the old country. He speaks Russian, and has a practice of twenty-five years. He cures with the best remedies chronic and all diseases. Do not lose any time. Come promptly to his office. Advice free. Visiting hours from 9-8; Sundays from 10-1.

The immigrant has heard of Abraham Lincoln even in his far-away native land. A quotation from him introduces an account of Doctor Liverpool's consummate skill in curing whatever is your ailment. How splendid this doctor must be who has ideals expressed by a quotation from Lincoln! A large picture of the doctor heads his advertisement.

So every human emotion is appealed to. Fear and anxiety are played upon. "Take every cough seriously" is only slightly less ominous than, "Blood disease digs the graves of millions." Perhaps, harassed by economic pressure, the immigrant is soothed by "try it at our expense" or "consultation and examination free." What to a more sophisticated person would seem incredible, to the bewildered immigrant spells a last resort. "I can tell you immediately from what you are suffering by *simply*

THE MEDICAL QUACK

looking at you." "I cure with success every disease." The testimonial from some person who claims to have been cured immediately is taken at its face value. Such is the unsavory range of advertising methods found in all too many foreign-language newspapers.

The letters as well as the newspaper advertisements play upon fear of sickness, fear of operations, fear of pain, fear of death, fear in women of the dangers of childbirth. Doctor Whittier's letter says:

Remember the poet said:

"Of all sad words of tongue or pen
The saddest are these,
'It might have been.'"

Ah, the pathos of these words, "It might have been!" That is, it might have been life instead of death for me! Remember, every day you will get a little worse.

The follow-up letters from Doctor Williams rise to a climax. Each is more frightening than the last. The following quotations are the key sentences to three successive letters.

1. If there is a cancerous condition present, it is dangerous and should have immediate treatment.

2. You know that cancer grows worse, never better; sometimes slowly, but in the end it always progresses.

3. YOU have a cancer. You know that nature offers no hope of a cure, and that your days are numbered.

The Get Thin and Get Fat advertisers play upon our pride of personal appearance and sensitiveness to other people's remarks about how we look. Thus Doctor Newman works to make you thin. "That

IMMIGRANT HEALTH AND COMMUNITY

you are too stout and would like to reduce your superfluous fat you know very well" is as appealing as "to live again free from fat and worry." A final blow at the very roots of individual pride is struck in "You are doing nothing to safeguard your social position. You *know* that your figure has lost the graceful outlines it once had, that was so pleasing to you and to every beholder."

On the other hand, Viratole will make you fat. No ingenuity is spared in seeking to arouse the sluggish desire of the thin. "The thin, nervous man is the one who suffers the horrors and the humiliation of looking starved." "Surely a woman who has the appearance of a broom handle is far from being a pleasing sight on the street." Social pressure is again applied: "Many a man is ashamed to go on the street with his wife because she is so thin looking." "On all public jobs where many men meet it is always the thin and sickly-looking fellow who is laughed at, and very often called names which are surely an insult to his bad fortune."

For those of us who are of a sentimental temperament come messages sounding the praises of the saintly advertiser: "Do not lose faith in Humanity. Having the means in our hands to do so much good, we beg of you not to think of us as having a soul so small as to put everything on the dollar basis." This spirit of friendliness is no doubt acceptable to the stranger: "We have missed your letters for some time, and inasmuch as we are really interested in your welfare and sincere in our desires to help you . . ." The pleasant platitude may turn the scales in favor of the doctor: "To do a kindness for

THE MEDICAL QUACK

others is the greatest happiness one can experience." If a man is a good patriot how impressive is the photographic reproduction of five orders written upon War Department paper to the Plapao Company for their Adhesive Pads!

If one is unable to resist the marvels exposed in correspondence with the quack, there are either medicines or professional treatment available. The medicine may be mailed directly from the factory, as in the instance of the Mollinger Medicine Company or the Antonina De Anna Chemical Company, or, as in the case of Nuxated Iron, it may be purchased in any drug store. Medicines are often advertised by the drug-store men themselves, who build up trade by featuring special goods. As examples may be mentioned the Crown Pharmacy, the Red Cross Pharmacy, St. Elizabeth's Drug Store, Niedlich's Drug Store, and the Metropolitan Drug Store. If you are persuaded that professional treatment is the only way out, one group of doctors advertise office hours, but will also give home treatment or send advice by mail, if you so desire.

The largest class, and undoubtedly the greatest mischief-makers, are those who advertise office treatment under the name of a physician, a company, or a medical institute. These urge patients to come to finely equipped offices or "private institutes." In the advertisement of Doctor Lyons we read, "Consultation and complete examination free." This complete examination extends even to the clothes, the pocketbook, and the bank book of the patient.

While a number of the medicines and appliances were sent for during this study, there was no inves-

IMMIGRANT HEALTH AND COMMUNITY

tigation of the medical institutes because a vivid picture of their operations is given in the report¹ of an investigator for the New York State Bureau of Industries and Immigration, prepared in 1914. It will be quoted only in part:

A sumptuous office is fitted up and an imposing trade name is adopted. . . .

The applicant is ushered into a private office. To comply with the law, a registered physician, under whose name the institute operates, and who is very often only an instrument in the employ of an unregistered financial backer, in addition to two or three interpreters all representing themselves as physicians, take the patient in hand. He is placed before a large machine of complex appearance that conveys the impression to the ignorant immigrant of being costly and almost miraculous, and is examined by the two or more interpreters, who, dramatically and with apparent emotion, inform the patient that he is suffering from some dreadful disease, which if longer neglected will result in death. The patient becomes alarmed and agrees to pay any price for a cure, which is guaranteed. A large amount is at first requested as part payment, but any amount that the patient has or can obtain is accepted. It is unnecessary to state that the so-called examination and the later "treatment" are absolutely without merit and that unregistered assistants are acting as physicians and "treating" the patient. No prescriptions are given, as the so-called institutes provide and sell directly all medicines and medicinal appliances.

The following complaints are typical of the numerous complaints on file with this bureau, and describe the methods of these so-called institutes:

C. D., a Greek laborer, twenty-three years of age, two years in United States, received a circular in the Greek

¹ *Fourth Annual Report, New York State Bureau of Industries and Immigration, 1914, pp. 257-258.*

THE MEDICAL QUACK

language, issued by one of the so-called medical institutes. Feeling somewhat ill, he called at said institute for "free" consultation and advice. He was examined and told that he was suffering from a dangerous disease. He was asked to pay \$7 for the examination, but only paid \$2, all the money he had, and was asked to sign an order for \$5 more on a private bank where he had \$80 on deposit.

It developed that the amount of this order was left blank and subsequently it was made out for \$73, which the physician withdrew from the bank. The patient soon found out from the private banker that his bank balance was \$7—as all the other money had been withdrawn. The bureau succeeded in obtaining the return of his money.¹

Mrs. S. R. was also induced through a circular she received to bring a child two years old to one of these institutes. Before examining the child the professor asked Mrs. S. R. for \$7, which she paid. Without examining the child, pills were prescribed and given for the child. Mrs. S. R. was instructed to return with the child in a few days with \$19—the balance of the fee required. The child, unable to swallow pills, was taken to the institute by the mother the following day and liquid medicine was now given, but when Mrs. S. R. stated that she was unable to pay the balance of \$19 the medicine was taken away. The child's condition thereafter became so serious that it was necessary to take her to a hospital. Refund of the money paid was obtained through action by this bureau.

Two investigators disguised as immigrants called at a certain "institute" which had distributed circulars and were examined by an unregistered "physician," who charged \$2 for the examination. The investigators were told that one of them was in the last stage of consumption and unless immediately treated would not live longer than one month. The institution guaranteed to cure for \$50. The investigators, before going to the institute, were examined by the department of health physicians, and after leaving

¹ *Fourth Annual Report, New York State Bureau of Industries and Immigration, 1914, p. 259.*

IMMIGRANT HEALTH AND COMMUNITY

the "institute" by a private physician; and they were found to be in perfect health. The bureau succeeded in having all the money collected from a large number of complainants returned to them and the proprietor has since discontinued the entire business.

One of these so-called professors who was not a registered physician confessed and disclosed some valuable information in a statement to this bureau which in part asserts that before examination the patient is asked to undress in an ante-room and there his clothes are searched for bank books, money, etc., so as to enable the person examining him to judge how large a fee to demand. . . .¹

This describes only some of the more outstanding and typical methods of the quack doctor. He uses whatever devious and subterranean means occur to him at the moment to lure his victims on. How he escapes from responsibility when he has guaranteed a cure and failed to help—perhaps even made matters worse—one may conjecture more easily than describe. Often he can put it back upon the patient, saying he has not obeyed orders, or has not taken his medicine regularly, or has not "kept on long enough." Doctor Faker is usually wise enough to have a legal adviser who could undoubtedly answer the question for us. A study of his methods is sufficient to condemn him, however, and afford a basis for the discussion of how to deal with him.

Agencies and powers exist in our society which deal or are capable of dealing with this monstrous evil of the quack. His frauds have been investigated by the American Medical Association and exposed in the American press. The foreign-language newspaper

¹ *Fourth Annual Report, New York State Bureau of Industries and Immigration, 1914, p. 260.*

THE MEDICAL QUACK

has the power to put him out of business by refusing to print his fraudulent advertisements. There is both Federal and state legislation framed to control his activities, and certain health organizations, public or private, seek to bring him to justice. It is obvious that these forces are not yet sufficiently developed to meet the situation.

EXPOSURE THROUGH PUBLICITY

In 1905 Mr. Samuel Hopkins Adams in *Collier's Weekly* called the attention of its readers to the enormity of quack frauds in some vivid and reliable articles. The *Chicago Tribune* followed up the work of exposure. Dr. Harvey Wiley, in popular writings in *Good Housekeeping* and elsewhere, has made people think and question a bit before buying cure-alls and wonder remedies.

The American Medical Association has done and is doing valuable work in laboratory analysis of many quack preparations and patent medicines and in the publication of many articles and pamphlets on nostrums and quackery. The following pamphlets and others can be secured from the American Medical Association at 535 North Dearborn Street, Chicago: "Cancer Cure Frauds," "Consumption Cures," "Convictions Under the Food and Drugs Act," "Epilepsy Cures," "Female Weakness Cures," "Medical Institutes," "Men's Specialists."

These publications, however, reach few of the laity, and one might guess that the average doctor is too busy to do much in spreading the information that is at hand. The more popular articles in newspapers

IMMIGRANT HEALTH AND COMMUNITY

and magazines have had some effect upon native public opinion, but they could not be expected to reach the great mass of immigrants.

RESPONSIBILITY OF THE FOREIGN-LANGUAGE PRESS

Although a certain amount of business comes to quacks through circulars or personal connections, newspaper advertising supports the big end of the business. The great majority of foreign-language newspapers accept quack advertisements indiscriminately, and to this extent they are party to their frauds.

An analysis of our quack and patent-medicine advertisements was made on the basis of the advertising rates sent by the publishers of the papers. Sixty-two papers sent us their rates. Of these, fifty-three had medical advertisements. The accompanying table gives in detail the amount of space devoted to medical advertisements in one issue, selected at random, of each of a number of newspapers. All are from about the same period in 1918. The estimated income from these advertisements is calculated from the rates as given, and what per cent it bears in each paper to the total advertising income is estimated from the space utilized at the various rates. This showed that the income to the newspapers from medical advertising was usually a considerable percentage of their income from their whole advertising. The table also classifies the papers according to language. It may be seen that as a rule the papers of the nationalities which have arrived more recently derive larger proportions of income

THE MEDICAL QUACK

from medical advertisement. This is not invariably true, but the trend is sufficient to warrant the generalization that the more helpless immigrants are the most exposed to exploitation of this sort.

TABLE XXII

**PERCENTAGE OF ADVERTISING INCOME DERIVED FROM MEDICAL
ADVERTISING IN CERTAIN FOREIGN-LANGUAGE NEWSPAPERS**

LANGUAGE	PAPER	LOCATION	PER CENT
Arabian.....	<i>Al-Fatat</i>	Boston.....	5
	<i>Daily Mirror</i>	New York...	9
Armenian.....	<i>Azk</i>	Boston.....	20
	<i>Bahag</i>	Boston.....	0
	<i>Gotchnag</i>	New York...	0
	<i>Hairenik</i>	Boston.....	25
Bohemian.....	<i>Amerikan</i>	Chicago.....	11
	<i>New Yorske Listy</i>	New York...	30
Croatian.....	<i>Narodni List</i>	New York...	59
Danish.....	<i>Den Danske Pioneer</i>	Omaha.....	10
Finnish.....	<i>Pohjan Tähti</i>	Fitchburg...	5
	<i>Päivelähti</i>	Duluth.....	20
French.....	<i>L'Indépendant</i>	Fall River...	7
	<i>L'Opinion Publique</i>	Worcester....	18
	<i>Courrier des Etats-Unis</i>	New York...	10
German.....	<i>Abendpost</i>	Chicago.....	10
	<i>New Yorker Herald</i>	New York...	12
	<i>Deutsch - Amerikanischer Farmer</i>	Lincoln.....	6
	<i>Lincoln Freie Presse</i>	Lincoln.....	0
Greek.....	<i>Greek Star</i>	Chicago.....	0
	<i>National Herald</i>	New York...	10
	<i>Prometheos</i>	San Francisco	20
Hungarian.....	<i>Amerikai Magyar Nepszava</i>	New York...	40
	<i>Magyar Muskaslap</i>	New York...	0
	<i>Szabadsag</i>	Cleveland....	20

IMMIGRANT HEALTH AND COMMUNITY

LANGUAGE	PAPER	LOCATION	PER CENT
Italian.....	<i>Il Minatore</i>	Scranton.....	21½
	<i>Il Progresso-Italo-Americano</i> ..	New York...	60
	<i>Bollettino della Sera</i>	New York...	35
	<i>L'Italia</i>	San Francisco	23
	<i>La Notizia</i>	Boston.....	20
	<i>La Voce del Popolo</i>	Detroit.....	13
Lithuanian.....	<i>Lietuva</i>	Chicago.....	20
	<i>Sandara</i>	South Boston	6
	<i>Darbininkas</i>	Boston.....	25
	<i>Amerikos Lietuviai</i>	Worcester....	18
Mixed.....	<i>United Mine Workers' Journal</i>	Indianapolis.	0
Norwegian.....	<i>Tidende</i>	Minneapolis.	6
Polish.....	<i>Pennsylvanski Gornik</i>	Scranton.....	0
	<i>Ameryka-Echo</i>	Toledo.....	60
	<i>Przewodnik Katolicki</i>	New Britain.	45
	<i>Straz</i>	Scranton.....	40
	<i>Kuryer Codzienny Bostonski</i> ..	Boston.....	35
	<i>Piast</i>	Chicopee.....	6
	<i>Dziennik Dla Wszystkich</i>	Buffalo.....	25
Portuguese.....	<i>O' Popular</i>	New Bedford.	5
	<i>A Alvorada</i>	New Bedford.	3
Roumanian....	<i>America</i>	Cleveland....	9
Russian.....	<i>Russkoye Slovo</i>	New York...	30
	<i>Amerikansky Russky Viestnik</i>	Homestead..	5
Slovak.....	<i>Nove Casy</i>	Chicago.....	0
	<i>Krojan</i>	New York...	20
	<i>Slovak v Amerike</i>	New York...	55
Slovenian.....	<i>Glas Naroda</i>	New York...	50
Spanish.....	<i>La Prensa</i>	New York...	2
Swedish.....	<i>Nordstjernan</i>	New York...	20
	<i>Osterns-Weckoblad</i>	New Britain.	21½
	<i>Svea</i>	Worcester....	16
Ukrainian.....	<i>Swoboda</i>	Jersey City..	50
Yiddish.....	<i>Jewish Daily News</i>	New York...	10
	<i>Vorwärts</i>	New York...	10
	<i>Warheit</i>	New York...	17

THE MEDICAL QUACK

It is right to mention with emphasis a certain group of progressive or altruistic papers whose publishers refuse medical advertisements altogether or censor the few that they do publish. The stand taken by these papers is best shown by quotations from their letters, written in reply to our request for rates.

This newspaper does *not* accept medical advertising, because it cannot help entertain the feeling that most of the medical advertisements in the foreign-language press are not straight. Since it is very hard to draw the line, we made it a rule not to consider such advertising offers, in spite of the fact that the expenses of getting out publications nowadays are mounting every day.—*Magyar Muskaslap* (Hungarian), New York City.

We feel very sorry to state that for some time past our paper has refused all *medical* advertisements.—*Le Courier Franco-Americain*, Chicago.

Medical advertisements subject to approval of publishers.—*Tidende* (Norwegian), Minneapolis.

Medical advertisement limited to business cards with name, address, and business hours of professional physicians.—*Atlantis* (Greek), New York City.

In regard to our rate for medical advertisement, will say that we would desire to receive a copy of the advertisement that you are contemplating to publish, as we are only accepting limited amount of medical advertisements, and we shall quote you our advertising rate.—*Den Danske Pioneer* (Danish), Omaha.

Before you place your advertisement please let us know what nature is your advertisement going to be, as we do not put advertisement in the paper that would harm our clean reputation and the readers of this newspaper.—NEW TIMES PUBLISHING COMPANY (Slovak), Chicago.

No special rates given for medical advertising. In fact, we don't cater to such advertisements unless they are the best kind. . . .—*The Greek Star*, Chicago.

IMMIGRANT HEALTH AND COMMUNITY

The Geringer Press—which publishes eight papers for Bohemians in Chicago, Cedar Rapids, Iowa; Prague, Oklahoma; Baltimore, Maryland; and East Pittsburgh, Pennsylvania—refuses all advertisements offering medical treatment by mail, but does accept patent-medicine advertisements.

Amerikansky Russky Viestnik, Homestead, Pennsylvania (Russian and Slavic editions), writes that medical advertisements “must be devoid of reference to private diseases.”

The fact that four of these publishers are in Chicago suggests that the antiquack campaign carried on by the *Tribune*, the American Medical Association, Doctor Krasnow, and others is showing positive results.

Nevertheless, among more than a hundred foreign-language newspapers examined, a very small proportion refuse medical advertisements. A few more accept them with limitations. Apparently most papers accept anything that will bring in money. We must conclude that the majority of the foreign-language newspapers share the profits of quackery. Some papers draw more than half their incomes from improper, illegitimate, or fraudulent medical advertising.

The foreign-language newspapers are an inevitable and necessary feature in American journalism as long as we have thousands of residents and citizens who, whether or not they read English, also read their mother tongue. While legal restrictions upon certain types of advertisement are urgently needed, one of the most effective and immediate means of diminishing the medical advertising in the foreign-language

THE MEDICAL QUACK

newspapers is to provide other sources of income. Obviously, newspapers that depend upon a certain class of advertisements for from 20 to 60 per cent of their total receipts from advertising cannot suddenly surrender it and live.

The American Association of Foreign Language Newspapers, recently reorganized under the leadership of well-known business men, has begun to call to the attention of American advertisers the opportunities offered by the foreign-language press. In the summer of 1919 a full-page advertisement was printed prominently in leading American papers throughout the country under the heading:

THE FOREIGN MARKET IN THE UNITED STATES

WHY IT PAYS THE BUSINESS MAN TO USE THE FOREIGN- LANGUAGE PRESS

"Here is a new, large, and fertile field in which to sell your goods," says the American Association of Foreign Language Newspapers to the American advertiser. "You can make money by using the foreign-language newspapers. At the same time you will be helping to Americanize the foreign born. The American standard of living is developed through the use of American products, such as toothbrushes, graphophones, sewing machines, cash registers, candy, seed, harness, furniture, books, banking, etc. Good Americanism is good business."

Since the foreign-language newspapers are (and must be) a factor in the transition of the foreign born from immigrant to American citizen, let us see to it that these newspapers introduce the best of America,

IMMIGRANT HEALTH AND COMMUNITY

not the worst, to their readers. Let us encourage American business men and women who have creditable goods to sell to advertise their wares in the foreign-language press. The readers will be benefited by having an opportunity to buy American products, and they will become familiar with American habits and tastes in a perfectly natural way. Then the publishers who are now struggling to keep their papers going will be able to say to medical quacks and all other frauds: "We don't want your ads; we have something better to put before our people. Thank you, but we do not *need* your money; our business is already very good."

The foreign-language press can be helpful in another direction. Announcement of the worthy medical resources of the community may well be made through its columns. For instance, there may be published the names and addresses of dispensaries and hospitals, of nursing associations, health departments, the headquarters for the public school's work in hygiene. Some responsible board, local or state, ought to furnish suitable material for such a list. Many papers would find their readers interested in a health department; many communities or societies would find their members interested in a health circle, with lectures from doctors who speak their own language. The foreign-language newspapers could encourage such circles by announcing meetings, reporting lectures and papers read, and recommending desirable books.

FEDERAL LEGISLATION

As a weapon to deal with this situation public opinion is an effective but a slow one. More immediate re-

THE MEDICAL QUACK

sults can be obtained through the operation of certain state and Federal laws. One of the most powerful of these is the Federal law commonly called the Fraud Order law.¹ This gives the Post Office Department the authority to close the mails to anyone using them in schemes to defraud. Before issuing a Fraud Order the Post Office authorities collect enough evidence to be sure that the man or concern is really defrauding through the mails. There is no public trial, but a hearing before the Postmaster-General or his deputy. The quack has a right to appeal to the courts, but in few cases has he done so, and in no case has the decision of the Post Office Department been reversed. Fraudulent business involving thousands of dollars has been wiped out by this means.

The Post Office Department began the active use of this power about 1914, but up to 1919 had hardly touched the foreign-language advertisers. The report of the Solicitor-General of the Post Office Department to the Postmaster-General (1916) announces that the use of the Fraud Order is becoming generally known and appreciated and that the movement among publishers for truthful advertising is growing.²

The activity of the department in prohibiting the use of the mails for the conduct of fraudulent schemes has become generally known to the public, with the result that this office is flooded with complaints against the alleged fraudulent schemes from all sections of the country. It is difficult to handle all of these in an efficient way with the present force. . . . This campaign for truthful ad-

¹ United States Criminal Code, sec. 215.

² *Report of the Solicitor for the Post Office Department to the Postmaster-General, for the year ending June 30, 1916, p. 5.*

IMMIGRANT HEALTH AND COMMUNITY

vertising is resulting in a great change in the nature of advertisements carried by many newspapers and periodicals, and in the conservative tone which is becoming more and more characteristic of the advertising of legitimate business. Its effect is also to be seen in the fraudulent advertising laws which have recently been passed by many state legislatures and by Congress in legislating for the District of Columbia.

The Fraud Order is a powerful instrument, the use of which in a democratic society should be carefully safeguarded. It should, however, be applied much more aggressively to the suppression of quacks. The number of cases that the Post Office Department can investigate and prosecute depends, of course, on the appropriations available. Every dollar devoted to this work saves thousands of dollars wrung from the poor and unfortunate. Translations of foreign-language advertising are as necessary as were translators in search of disloyalty. Public health organizations, medical and civic bodies should urge the appropriation of sufficient funds to institute a systematic weeding out from the foreign-language press of all advertisers which can be reached by this law.

There is now pending before Congress a bill "to prevent transmission through the mails of advertisements relating to the treatment of venereal diseases and certain sexual disorders." Should this bill become a law it would interfere with the business of a great number of prospering quacks. A number of states already have such laws relating to posters and circulars. This provision cannot be urged too strongly, and it should be followed as rapidly as public opinion permits by similar restraint of the

THE MEDICAL QUACK

exploitation of cancer, tuberculosis, and other diseases.

The "patent" medicines, which are rarely patented, and the proprietary medicines, which are practically identical with the so-called "patent" medicines, are covered by the Food and Drugs Act of 1906, commonly known as the Pure Food law. This law has done a great deal of good by fixing responsibility for products both in food and in drugs, but its common name, Pure Food law, has made people think that everything bearing its guaranty, name, or number is altogether admirable. This is a serious mistake. Its provisions and its field of application are both limited. The Food and Drugs Act applies only to products in interstate commerce—things manufactured and sold within the boundaries of a single state are not affected.

If a drug product is to be sold in states other than the one in which it was manufactured, it must fulfill certain conditions. Its "label," which by the interpretation of the courts includes all the contents of the package, must state whether it contains alcohol, morphine, opium, cocaine, heroin, alpha-eucain or beta-eucain, chloroform, canabis indica, chloral hydrate, or acetanilid, or their derivatives. These eleven drugs and their derivatives must be declared, with the amount of each used. But other poisonous drugs, such as aconite, arsenic, carbolic acid, prussic acid, and strychnine, may be used and not declared.

The patent-medicine manufacturer must be careful in the statements he makes in the trade package, which includes the bottle, its label, and all circulars, boxes, or cases that go with it. He must make no

IMMIGRANT HEALTH AND COMMUNITY

statement which is false or misleading about the composition and origin of his medicine, and he must be careful not to make false or fraudulent claims for its curative virtues. Doctor Cramp, of the American Medical Association, puts this very clearly:¹

Under the Food and Drugs Act, then, the manufacturer of a medicinal product may be declared guilty of misbranding if the statements he makes (on the trade package) regarding the composition or the origin of his products are either "false or misleading"; he may also be found guilty of misbranding if the statements he makes (also on the trade package) regarding the curative effects of his preparations are both "false and fraudulent."

However, the patent-medicine maker and seller slips by Uncle Sam's grave requirements very easily and happily. He then betakes himself to the newspapers, in which he can make practically any boast of the curative effects of his medicine. No one molests him, and the people believe him, for in their minds does not the Pure Food law also insure them pure medicines?

Doctor Cramp gives us this clever rule for finding the false ingredient in a newspaper advertisement for patent medicine:

From the claims made in the newspaper advertisements and circulars subtract those that are made in the trade package; the difference, you are justified in assuming, is falsehood!

STATE LEGISLATION

Besides these Federal laws, various states deal separately with the medical quack. During the past

¹ Arthur J. Cramp, M.D., "The Nostrum and the Public Health," reprint from *The Journal of the American Medical Association*, May 24, 1919, p. 4.

THE MEDICAL QUACK

two years nine states have passed laws prohibiting the advertising of treatment for venereal diseases, and in some cases the advertising of nostrums to treat these diseases. This legislation was in most instances the result of the war-time campaign against venereal diseases. It has undoubted value, but two limitations must be pointed out.

As these are state laws, they do not affect business done through the mails, as such. These state laws, and the Federal law, however, are mutually supplementary, and each is necessary to the other's most complete effectiveness.

Quacks often get around these laws by using a form of words which does not come strictly within the wording prohibited by the terms of the statute. Then they trust to a narrow legal interpretation to save them should they be prosecuted.

In addition to these special laws the legislation of each state in the Union regulates the practice of medicine within its own borders. These medical-practice acts need to be strengthened in some respects. The custom of recognizing by courtesy and without new examinations a doctor who has been registered and licensed to practice in another state covers many abuses of quackery.

These state laws regulating the practice of medicine apply to obvious cases. Under them a man, posing as a doctor, "practicing medicine" without legal license to do so, can be prosecuted and convicted. So can the licensed fraud. A doctor who has started out honestly enough may fail to make a success of ethical practice; he may start a profitable "institute" or a business by mail; or he may hire himself

IMMIGRANT HEALTH AND COMMUNITY

to some "professor" and for a small, regular salary—twenty-five dollars to fifty dollars a week—do the "examining and prescribing" while the "professor" takes in from two to eight thousand dollars monthly. The license of such a man can be revoked, and he may be punished further if he is found guilty of actually taking money with the intent to defraud.

The hospital or dispensary has only just begun to come under public supervision, although it is sound policy that any organization doing public work should be under some degree of public supervision. The delay has probably been due to a theory that the public interests were protected by the licensing of individual practitioners of medicine, who must be the active professional agents in these institutions. It has come to be recognized, however, that the institution, as such, should be under direct supervision of a health authority representing the public; consequently state or local laws licensing hospitals or dispensaries are being passed. New York, Massachusetts, and Ohio are examples of states in which dispensaries must be licensed. The Massachusetts law defines a dispensary as follows:

SECTION I. For the purposes of this act a dispensary is defined to be any place or establishment, not conducted for profit, where medical or surgical advice or treatment, medicine or medical apparatus, is furnished to persons non-resident therein; or any place of establishment, whether conducted for charitable purposes or for profit, advertised, announced, conducted or maintained under the name "dispensary" or "clinic," or other designation of like import.

Any organization advertising itself as a clinic, dispensary, or medical institute would come under this

THE MEDICAL QUACK

law, and therefore under the supervision of public authority. In the case of Massachusetts this is the State Department of Health, but in Chicago it is the City Department. In any case, the license law gives to some public authority a power to acquaint itself with facts through inspection, and to use these facts for public information. During the first year of operation the Massachusetts Dispensary law, passed in 1918, put out of business nine quack or commercial dispensaries in the city of Boston.

LAW ENFORCEMENT

The value of all these laws, however, depends upon their aggressive enforcement. Their purpose is often defeated because the person who has suffered from the quack fails to make a complaint. Only after the public realizes that it is being defrauded will it look for the law to redress its grievance. Many immigrants are so unsuspecting that they are easily fooled. Even if they do appreciate that they have been duped, their ignorance of English, or of the means of legal redress, usually renders them passive. It is neither just nor wise that the public should thus place the responsibility of initiative upon the individual who is aggrieved. An aggressive public agency, rather than a passive one, is needed for the adequate protection of the immigrant against the medical quack.

Beginnings in this direction have been made by various agencies, both public and private. Prominent among these are the state bureaus of immigration. The California Commission of Immigration and Housing, whose work is notable in so many ways,

IMMIGRANT HEALTH AND COMMUNITY

has received and dealt with complaints of medical frauds, but as yet it has not taken up any special campaign against this evil. The Massachusetts Bureau of Immigration is too recent to have developed this work, but it is studying the subject. The longer established Bureau of Industries and Immigration, in New York State, which is a branch of the State Department of Labor, has accomplished more in this direction.

Many immigrants are slow to voice their troubles except to people or to an organization which has won their confidence, and for this reason the establishment of bureaus of immigration under state or city auspices is a desirable movement, by whatever title they may be called. In planning such bureaus full provision should be made, both in the organization and in the appropriations, for sufficient power to receive, investigate, and deal with complaints of medical fraud. Such bureaus should be prepared to make investigations on their own account and to awaken public opinion, so as to secure support for vigorous enforcement of the law and for adequate sentences for the quacks.

Voluntary organizations dealing with health problems can assist here. Public health committees, anti-tuberculosis societies, nursing associations, can, by publicity as well as through direct co-operation with bureaus of immigration, reveal instances of quackery and awake the public to its meaning. Not a few medical societies, notably that of New York County, have undertaken work along this line.

It would seem to be good policy for a medical society to act as an investigating, stimulating, and

THE MEDICAL QUACK

publicity agent, rather than a prosecuting body. Certain elements among the public, newspapers, and even courts discount what the medical profession does or attempts to do against quacks, on the ground that one business competitor is attacking another. Ill-founded as this feeling is, it must be reckoned with.

The Health Department of a city has authority with the sources of publicity in the newspapers and elsewhere. They look upon the Health Department as the natural agency to speak in a definitive way regarding any medical or health question. In enlightening the public concerning the evil doings of the quack, the powers of the Health Department are limited only by the courage of the commissioner and his judgment of the educational and political effects of a campaign that might be construed as an attack by certain medical institutes or by patent-medicine interests. Few departments have made use of the power they might wield through bureaus of public health education, or through their general activities if they have no such special bureau, to protect the public against the quack.

The experience of the New York Department of Health in connection with patent-medicine venders is of interest. In 1915 the New York City Board of Health passed an ordinance requiring that the ingredients of all packages of patent medicines be printed on the label. The powers under which this ordinance was passed were the general sanitary powers of the department to protect and promote the public health. The ordinance was contested in the courts, and was finally declared unconstitutional

IMMIGRANT HEALTH AND COMMUNITY

by the New York State Court of Appeals, but the ruling of the court was on the technicality that the ordinance had not provided for the protection of the property of those who, previous to the passage of the Act, had in stock, or had prepared for sale, proprietary medicines not properly labeled.

The principle of the law requiring publicity of the ingredients of each package and the authority of the department to pass such an ordinance were not declared unconstitutional by the court's decision. It is much to be hoped that departments of health will undertake to enact and enforce ordinances of this character, and have them suitably tested in the courts. Public opinion is moving forward so rapidly in these matters that the reasonableness of the requirement that the ingredients of a medicine be printed on its label ought soon to meet the approval of everyone who has no special interest to serve.

Although these various agencies have power to fight the quack and may in time develop it adequately, the results so far accomplished are not encouraging. The following cases are reported by the Bureau of Industries and Immigration in New York State.¹

One of these offices, operating in the name of "Doctor Hannon," but in charge of a man named Noack, recently demanded and received \$130 as a first payment for a guaranteed "cure." This "doctor" was one of those who had received a suspended sentence when convicted in 1915, and this bureau was obliged to determine whether the poor immigrant should lose his money or proceed again to prosecute Noack. A demand was made for the immediate

¹ *Annual Report, New York State Bureau of Industries and Immigration, 1916, p. 9.*

THE MEDICAL QUACK

return of the money, and Noack, accompanied by two attorneys, appeared at this office. The next day a check was received for the entire amount.

Further extracts from the reports illustrate the urgent needs for adequate punishment of the responsible person:¹

Investigations conducted by the bureau show that these museums and their so-called "doctors" obtained many thousands of dollars weekly, defrauding foreigners. The proprietor of one of the larger offices stated that unless the profits averaged \$4,000 a month it would be closed. One of the worst offenders was a man named Henry J. Shireson.

This man Shireson was prosecuted for violation of the Public Health law, convicted, and sentenced to six months in the penitentiary.

Now read this from the report ² of the same bureau for the very next year, 1916:

During the year one Henry J. Shireson, who had served six months in the penitentiary in this state, was released. He immediately opened an office in Utica under the name of Doctor Fanning and with his female confederate proceeded to advertise and distribute the old familiar type of circular. He succeeded in swindling the immigrant population of Oneida County of about \$36,000 in about six weeks. At the same time he had opened an office in Schenectady and accumulated about \$14,000. He was indicted for grand larceny in Utica and escaped; his assistant, Doctor Fanning, who was employed at a salary of \$25 per week as the dupe of this criminal, is now serving a term on an indeterminate sentence of from five to ten years in the Auburn state prison. The record of Shireson appears in the previous report of this bureau, but his reappearances in highly

¹ *Annual Report, New York State Bureau of Industries and Immigration, 1915, p. 15.*

² *Ibid., 1916, p. 8-9.*

IMMIGRANT HEALTH AND COMMUNITY

populated immigrant sections of the country is to be expected as long as he remains at large. He has been termed a dangerous criminal by the authorities of various other states and is a serious menace to the community, since he not only swindles these ignorant people of their entire savings, through appeals to their sense of self-preservation, but operates to the detriment of life and health by his unscrupulous deception, errors of diagnosis, and improper treatment.

Leonard Landes was prosecuted in New York by this bureau in 1915, and given thirty days and a fine of one hundred dollars. This is probably the "Leo Landes" whose advertisements we found in twelve different papers. No wonder that the quack can pay so much for advertising when he is taking in so much cash daily. No wonder he doesn't mind a small fine and a short prison term when his business can go on during his absence or be easily re-established when he returns.

The only ultimate protection for the individual against fraud lies in himself. But the educational process which develops wisdom in the individual is slow, so slow that we cannot depend on it to remedy urgent existing evils. The more quickly effective measures of legislation and administration must be utilized, while we still hammer at the long-range constructive work of education.

One of the chief characteristics of the quack is his cleverness. We can learn from him. The use of the foreign-language newspapers by quacks demonstrates that most of these medical advertisers are scoundrels, ignorant of medical science, but clever commercialists and expert practical psychologists. The manner in which they appeal to the immigrant, the methods

THE MEDICAL QUACK

which they use, are well worthy of study. Governmental agencies, health departments, private health organizations of all kinds, may well imitate the quack in devising clever ways to reach the immigrant, in learning to understand him and what will appeal to him. They will use this knowledge and power, of course, not to rob him and ruin his health, but to give him larger facilities for life and the pursuit of happiness.

IX

BIRTH RATES AND MATERNITY CUSTOMS

THE kind of care which women receive during the puerperal period is not only of great importance to the mother's comfort and future health, but also determines to a considerable degree the infant mortality rate and the health and efficiency of the next generation. If there is a difference in the care received by the native and the foreign-born woman during and after childbirth, it may account for the high infant mortality rate of our white stock of foreign extraction.

FECUNDITY AND MATERNITY DEATH RATES

Maternity care is particularly important to the health of the foreign born because of the high fecundity of immigrant women, and the high death rate for mothers as well as infants. The Immigration Commission's Report on the "Fecundity of Immigrant Women" records in 1900 that the average number of children born to women less than forty-five years of age and married ten to nineteen years was 2.7 for native-born mothers and 4.4 for foreign-born mothers.¹ Further comparisons made in 1909 of the fecundity of married women of the "old" and "new"

¹ *Reports of the Immigration Commission*, vol. ii, p. 497.

BIRTH RATES AND MATERNITY CUSTOMS

immigration show that the former averaged 3.5 children and the latter 4.9.¹ The use of the terms "old" and "new" immigration has been discredited since the report of the commission was published, but the contrast in birth rates between certain races is nevertheless worth observing.

A more recent study of comparative birth rates was made by Eastman for New York State in 1916.² Although his figures are not exactly comparable with the foregoing, the same marked difference between the fecundity of the native and the foreign-born mother is apparent. The average number of legiti-

TABLE XXIII
INFANT MORTALITY IN EUROPEAN COUNTRIES, 1908³

	BIRTH RATE PER 1,000	DEATH RATE PER 1,000	INFANT MORTALITY PER 1,000 BIRTHS
Great Britain.....	26	15	118
Denmark.....	28	14	106
Norway.....	26	14	76
German Empire.....	32	18	178
Austria.....	33	22	204
Hungary.....	36	24	199
Netherlands.....	29	15	125
France.....	20	19	143
Switzerland.....	27	16	108
Italy.....	33	22	153
Bulgaria.....	40	24	170
Russia.....	48	30	256

¹ Peter Roberts, *The New Immigration*, 1914, pp. 368-369. (Appended material abstracted from Immigration Commission's Report on "Fecundity of Immigrant Women," pp. 46-52.)

² P. R. Eastman, New York State Department of Health. *A Comparison of the Birth Rates of Native and of Foreign-born White Women in the State of New York During 1916*, 1916, p. 3.

³ Peter Roberts, *The New Immigration*, 1912, p. 373.

IMMIGRANT HEALTH AND COMMUNITY

mate births to every 1,000 married women fifteen to forty-four years of age was 137.1 for the native born and 253.2 for the foreign born. On an average almost twice as many children were born to foreign-born mothers as to native born. There is also evidence that a greater proportion of births were to mothers of the more recent immigration, for "73.1 per cent of all births to foreign-born women were to Italian, Russian, and Austro-Hungarian mothers." These high fecundity rates among the four races—Poles, Bohemians (or Czechs), Russians, and Italians—are of interest in connection with the infant mortality rates reported from these European countries (Table XXIII).

Figures relating to maternal deaths among these

TABLE XXIV

DEATH RATES FROM AFFECTIONS CONNECTED WITH PREGNANCY, 1900.¹ (DEATHS PER 100,000 FEMALE POPULATION, FIFTEEN TO FORTY-NINE YEARS OF AGE, IN THE REGISTRATION AREA)

WHITE MOTHERS BORN IN	DEATH RATE
United States.....	34.7
Italy.....	121.7
Russia.....	66.2
Poland.....	54.7
Hungary.....	52.6
Germany.....	52.7
England and Wales.....	50.7
Scandinavia.....	45.7
Canada.....	45.6
Ireland.....	45.1
Scotland.....	33.7
Bohemia.....	30.6
France.....	22.5
Other foreign.....	65.3

¹ *Twelfth Census of the U. S., 1900, Vital Statistics, vol. iii, p. ccxlviii.*

BIRTH RATES AND MATERNITY CUSTOMS

rates are scarce. The United States Census of 1900, however, contains some suggestive material (Table XXIV). The Italians, Russians, and Poles head the list in maternal mortality, standing in very much the same position as in the preceding table giving infant mortality rates abroad. The amount of evidence on hand is insufficient to reach any conclusion as to whether the cause of high maternity death rates is racial or environmental, or as to the relative importance of these two influences. The differences between races are so considerable and the subject itself is of so much importance that further investigation is much to be desired. It is to be hoped that figures secured from the 1920 census may be tabulated so as to bring out race elements in maternal mortality.

INADEQUATE MATERNITY CARE

It might be expected that the same resources for maternity care would be used by immigrant women as by natives of the same economic status. In large cities there are usually maternity hospitals and charitable agencies which are not found in middle-sized communities. In cities where medical schools exist and medical students are taught obstetrics, well-organized out-patient services have been developed, through which many women receive excellent care in confinement in their own homes, the difficult cases being brought to the hospitals. In smaller places there are no organized resources for providing care in confinement, and maternity beds in hospitals to which cases can be taken in an emergency are often lacking or are far below the number needed. The

IMMIGRANT HEALTH AND COMMUNITY

facilities in rural districts are still more limited, and women must depend upon attendants privately engaged.

Yet even in large cities cases unattended by physician, midwife, or nurse, or even by a neighbor, are far from unknown. In a study of maternity care made in Detroit in 1917 appears the following story:¹

Mrs. K., Hungarian, has four children. Husband acted as interpreter. When asked if a doctor or midwife was employed he replied: "Oh, she had her baby while I was at work—only the children here. She sat up in bed and cared for herself. Was out of bed on the second day after birth."

In this same survey of 2,000 maternity cases in Detroit, it was found that

. . . in the great majority of instances the time the patient remained in bed was determined, not by her physical condition, but by the assistance she was able to secure. The presence of boarders or roomers in the house at such times very materially shortens the time a mother is cared for in bed. Nationality also plays some part. It was found that daughters of foreign-born mothers remained in bed much longer than their mothers had been accustomed to. Foreign-born women who came to the United States at an early age and received their education in this country followed the customs of American women, rather than their relatives or fellow countrywomen. They remained, as a rule, longer in bed and had a distinctly higher standard of care.

In a study made in New York by the Association for the Improvement of the Condition of the Poor,

¹ "How Two Thousand Detroit Mothers Were Cared for in Childbirth," Detroit Home Nursing Association, Detroit, 1917, p. 11.

BIRTH RATES AND MATERNITY CUSTOMS

in two hundred and sixty-five maternity cases cared for by midwives, data showing the rest period after childbirth are of interest.

TABLE XXV
DAYS IN BED AFTER DELIVERY OF CASES CARED FOR BY MIDWIVES,
NEW YORK CITY, 1912-19

	UNDER 2 DAYS	2 TO 4	4 TO 6	6 TO 8	8 AND OVER	TOTAL
Number.....	4	58	100	73	30	265
Per Cent	1.5	21.9	37.7	27.5	11.3	100

Over 60 per cent of the women delivered by midwives stayed in bed only six days or less, while four women were in bed less than two days. What the effects of these short periods of rest after childbirth may be on mortality rates is a matter for conjecture.

Conditions that existed a few years ago in a city of middle size and that are still characteristic of many similar cities which we have studied, are depicted in the survey of Johnstown, Pennsylvania, by the Federal Children's Bureau, published in 1915.¹

Two thirds of those having no attendant (at birth) were Serbo-Croatians. It was a Polish woman, however, who gave the following account of the birth of her last child:

At five o'clock Monday evening went to sister's to return washboard, having just finished day's washing. Baby born while there; sister too young to assist in any way; woman not accustomed to midwife, anyway, so she cut cord herself; washed baby at sister's house; walked home, cooked supper for boarders, and was in bed by eight o'clock. Got up and ironed next day and day following; it tired her, so she then stayed in bed two days. She milked cows and sold milk

¹ Emma Duke, "Infant Mortality, Johnstown, Pennsylvania," Children's Bureau, United States Department of Labor, 1915, pp. 32-34.

IMMIGRANT HEALTH AND COMMUNITY

day after baby's birth, but, being tired, hired some one to do it later in week.

This woman keeps cows, chickens, and lodgers; also earns money doing laundry and char work. Husband deserts her at times; he makes \$1.70 a day. A fifteen-year-old son makes \$1.10 a day in coal mine. Mother thin and wiry; looks tired and worn. Frequent fights in home.

Frequently the Serbo-Croatian women dispense altogether with any assistance at childbirth; sometimes not even the husband or a neighbor assists. More than 30 per cent of the births among the women of this race took place without a qualified attendant. More than one half of those delivered by midwives, less than one fifteenth of those delivered by physicians, and about one fifth of those delivered without a qualified attendant had babies who died in their first year of life.

Fifteen of the nineteen Serbo-Croatian women whose babies died under one year of age kept lodgers.

The native mother usually had a physician at childbirth; the foreign born, a midwife. The more prosperous of the foreign mothers, however, departed from their traditions or customs and had physicians, while the American-born mothers, when very poor, resorted to midwives. The midwives usually charged \$5, and sometimes only \$3; they waited for payment or accepted it in installments, and they performed many little household services that no physician would think of rendering.

One or two of the intelligent graduate midwives in Johnstown have been an educational force among the foreign mothers for some years past. On the other hand, there were others who were so dirty and so ignorant that they were a menace to the public health. .

BACKGROUNDS FOR MOTHERHOOD

If neglect in confinement is more frequent for immigrant than for native women, the explanation may be found in various circumstances peculiar to the immigrant's situation in America.

BIRTH RATES AND MATERNITY CUSTOMS

Earlier chapters of this volume have described the typical social and economic conditions under which immigrant families live in American communities. Poverty and crowding, unsanitary houses and neighborhoods, are so frequent as to be almost characteristic, whether it is the immigrant's own fault or the fault of the American community, or some of each. Maternity care under these economic and social conditions presents difficult problems at best, but it is further complicated by barriers of language and differences in customs and points of view between the American medical and health worker and the immigrant.

No events of life are more interwoven with tradition and superstition than are pregnancy and birth. It is impossible to understand the situation which must be dealt with among immigrant women in this country unless we know something of their backgrounds and customs. Some of these are of interest merely to the curious; some have practical value for the health worker. It must be borne in mind that in different parts of a single country, such as Italy or Poland, these customs and traditions may vary widely, and that what is told one by a certain Italian mother as a long-rooted custom of her country may really be only a local one of her community or district.

Numberless traditions cluster about the care of the mother. A nurse who had had much experience working in Polish sections says:

As soon as a Polish woman is pregnant she gets a scrubbing job. No matter what her work may have been before, she now wishes to scrub.

IMMIGRANT HEALTH AND COMMUNITY

If there is a theory behind this it is probably that the exercise is good for the prospective mother. This woman was told that in Poland "a countess will scrub when she knows that a baby is coming."

Many Italian women are found to have a "superstition" against taking a bath during pregnancy. They tell nurses that this will cause an abortion or miscarriage. A wise nurse, who had lived in southern Italy, observed that their bathing there had been in the streams, lakes, or sea; the shock of cold-water bathing possibly brought trouble to the pregnant woman and may have been the source of a tradition against any bathing during pregnancy. This nurse is accustomed to explain carefully to her patients that while it was not well to bathe in Italy in cold water, out of doors, here in America the custom is to take a warm bath indoors, and that the bath will be a comfort to the mother and help to keep her well.

A frequent Jewish superstition seems to be that "a pan of water set under the bed of a woman in confinement will keep away poisons and bedsores." A Russian-Jewish superstition told by some midwives is that a pregnant woman must not look on the face of a dead person, or the baby will be born white. Another, that after the baby is born, if the mother will blow into a bottle, the placenta will come and all will be well. Workers among the Poles tell of the same bottle-blowing superstition. It has been suggested by some doctors and nurses that the muscular exertion of hard blowing may be of assistance in labor. Russians and Greek Catholics appear to have a tradition that the mother should be churched between four and six weeks after delivery.

BIRTH RATES AND MATERNITY CUSTOMS

One organization working with numbers of these people is taking advantage of this custom by getting the women to go to a clinic on that same day for post-partem examination.

Similarly, superstitions or customs regarding the care of the baby are numerous. The "Evil Eye" is a prevalent superstition among many immigrants from the Near East. "It is particularly bad to leave a baby naked," says one, "for if the Evil Eye then falls on him bad luck is soon on the way." Some Polish mothers apparently believe that if water touches a baby during the first week it will die before the end of the first year.

The customs of celebration at, or shortly after, the time of the baby's birth are of much importance. The ceremony of circumcision among the Jews, usually at the end of a baby boy's first week of life, is one example. Visiting and festivity to celebrate the birth of a baby are frequent among many groups. Some of these customs explain the unwillingness of immigrant women to go to hospitals for confinement. Visitors in the hospital must necessarily be restricted. Families and friends cannot come and go at will to see mother and baby, as they can in the home. What, then, is to become of an Italian custom that all the friends and relatives should come the day after the baby is born to wish him luck and a happy life? Charms and presents are brought the baby, and pinned on his clothing. Italian women will approach their confinement, particularly their first, with wonderful hand-woven linen sheets, embroidered pillowcases, and beautiful satin coverlets, often made by the mother herself during girlhood. What will

IMMIGRANT HEALTH AND COMMUNITY

be the use of these if she goes to the hospital, where she cannot use them, and where her friends cannot come to see her lying in state amid her finery?

Such customs are real parts of life. If American workers for health do not know them or understand them, if they take an indifferent or contemptuous attitude toward them, they can neither get the best from, nor give the best to, the people whom they seek to serve.

These few customs, traditions, and superstitions have been mentioned to illustrate the importance of knowing the people with whom we are dealing, their backgrounds and characteristics. There has been no thought of holding up to laughter or scorn any people, or even any superstition. They are historical products of human development.

The social composition of the immigrant family creates another difficulty for the American health worker. The immigrant mother has not the independence of the average American-born woman. Authority over all the members of a family, including the wife herself, is centered much more in the husband. Now the man of the family is often a difficult person for the health worker to reach. He is not at home during the usual working hours of the social worker or nurse. A medical adviser of a child-welfare undertaking in a large Middle Western city tells us that she found it necessary to put some nurses on at night to visit their immigrant families, because in that particular group the mother would not change the baby's diet, however deleterious it seemed to the American doctor or nurse, without receiving the father's permission.

BIRTH RATES AND MATERNITY CUSTOMS

The necessity of reconciling inherited customs with the conditions found in America has in many respects a far-reaching effect on maternity work for immigrant women. Perhaps the respect in which they differ most sharply from native born is in their extensive use of midwives.

The immigrant mother has rarely been accustomed to a man doctor at the time of confinement. She and her friends have used the midwife, who, in most European countries, is a woman of some standing, trained, and in many countries carefully supervised. The midwife is the most important single element in the general question of the care of immigrant mothers, and as such her capability and the quality of her work is of immense importance.

X

THE MIDWIFE

MIDWIVES in the United States bring into the world more than a million babies every year. Although we have no exact records for the country as a whole, information received from a number of states and many cities show it to be a conservative estimate that 30 per cent of all confinements are attended by midwives. The truth is probably nearer 40 per cent than 30 per cent.

Smaller detailed studies have been made from coast to coast. Boston has no official data, since midwives are not recognized by law in Massachusetts, and theoretically are not allowed to practice. Ninety mothers, selected at random from those attending the general clinic of the Maverick Dispensary in East Boston, two years ago, reported that of their 329 children born in this country, 59 per cent had been delivered by doctors, 25 per cent by midwives, 15 per cent by institutions, and three cases, or 1 per cent, had been unattended.

Of 529 mothers who received prenatal supervision from the Division of Child Hygiene of the Department of Health in Newark, New Jersey, 87.3 per cent were delivered by midwives, 9.6 per cent by doctors, 2.6 per cent in hospitals, and .4 per cent had no attendant. The number who used midwives is notable, since up to the time of delivery nurses of

THE MIDWIFE

the Department of Health had been supervising their pregnancy.

Variation in the per cents reported from the different places intimates that nationality must be taken into consideration. One of the most complete available studies of the factor of race is that for New York State. The following table compares the numbers of native and foreign-born mothers resorting to midwives: ¹

TABLE XXVI

BIRTHS ATTENDED BY MIDWIVES IN NEW YORK STATE, ACCORDING TO THE NATIVITY OF THE MOTHERS (NEW YORK CITY EXCLUDED), 1916

NATIVITY OF MOTHER	TOTAL BIRTHS	BIRTHS ATTENDED BY MIDWIVES	
		Number	Per Cent of Total Births
Native, white.....	64,889	2,504	3.9
Foreign born, white.....	37,914	14,165	37.3
England, Scotland, Wales.....	1,869	28	1.5
Ireland.....	1,879	29	1.5
Germany.....	2,296	633	27.6
Italy.....	12,998	5,276	40.6
Russia.....	3,665	1,174	32.0
Austria-Hungary.....	6,345	3,630	57.2
Poland (includes German, Austrian, and Russian Poles)....	4,703 .	3,112	66.1
Canada.....	2,219	44	2.0
Other foreign born.....	1,940	239	12.3

The difference in the proportionate use of midwives by native and by foreign-born mothers is the outstanding fact of the table. It is not possible, however, to lump the foreign-born mothers together in the generalization that they all have midwives. The

¹ *Thirty-seventh Annual Report, New York State Department of Health, 1916, p. 454, Table VII.*

IMMIGRANT HEALTH AND COMMUNITY

per cent of those who do varies among the races from 66.1 for the Poles to 1.5 for the English-speaking foreign born, a rate that falls below that of the native born. The high per cent for native-born mothers is probably explained by the fact that women of native birth employing midwives "were of Italian, Russian, or Austro-Hungarian parentage, and . . . the custom of the native country of their parents still held considerable sway."

A study of mothers in New York City found 56.2 per cent using midwives; 87 per cent of those using midwives were foreign born;¹ and 58 per cent of those foreign born were Italian. The use of midwives by Italian mothers is everywhere prevalent. In one study of two hundred and eighty-nine Italian deliveries, 91.7 per cent were attended by midwives.² A study of three cities in California showed that "the midwifery situation . . . is very largely confined to the foreign-born population, principally Italian and Japanese."³ From Chicago, Detroit, and Pennsylvania studies come similar findings.⁴ The foreign-

¹ Jacob Soble, M.D., "Instruction and Supervision of Expectant Mothers in New York City." Reprint from *New York Medical Journal*, January 19, 1918, pp. 16, 17.

² Compiled from material received from the Bureau of Educational Nursing, Association for the Improvement of the Condition of the Poor, New York City, 1918.

³ Mrs. Elwyn Stebbins, "Supplementary Report on the Midwives of Oakland, Alameda, and Berkeley," *Sixth Annual Report of the American Association for the Study and Prevention of Infant Mortality*, pp. 149-150.

⁴ *Report of the Health Insurance Commission of the State of Illinois*, May 1, 1920, p. 60. "How Two Thousand Detroit Mothers Were Cared for in Childbirth," Detroit Home Nursing Association, Detroit, 1917, pp. 1, 3, 6. Emma Duke, "Infant Mortality, Johnstown, Pennsylvania," Children's Bureau, United States Department of Labor, 1915, p. 60, Table IV.

THE MIDWIFE

born mothers, especially among the Italian and Slavic peoples, have not the habit of using physicians. Were there no foreign-born mothers there would be practically no midwife problem.

REASONS FOR USING THE MIDWIFE

The reasons why the foreign born use midwives so extensively are easy to understand from the facts of their background and their usual circumstances in this country.

One reason is the prejudice against having a man doctor. We hear much of the so-called sex prejudice of the foreign-born woman in this respect. There is no doubt that it exists to a greater or less degree, depending on the race and the individual. The husband, also, has a large part in determining whom the woman shall have and how much shall be paid. When, as is likely, he does not know any doctors, he must be brought to feel absolute confidence in a new and more expensive kind of service. He must be persuaded to let a strange man doctor render very intimate services to his wife, for he cannot usually afford a woman attendant also. There is reason to believe that the prejudice is sometimes given as an excuse for having a midwife when the real reason is economic, or simply strongly rooted custom.

Another reason for using the midwife is the tradition of capability carried over from foreign countries wherein these women have recognized professional status. Throughout Europe the midwife is a highly specialized trained person. In Holland, Belgium, France, and Italy, a full two years' course of training is required before a woman may practice

IMMIGRANT HEALTH AND COMMUNITY

midwifery. In Norway, Sweden, Denmark, and England the course is one year. In Germany she gets six months' training in government clinics, under university professors. In most countries abroad, moreover, the midwives are licensed and are carefully supervised by the state.¹ The mother may have already used midwives and known many of them through her friends abroad. The immigrant family has many reasons for implicit trust in the midwife.

The immigrants' chief reason for using the midwife, however, is economic. The midwife costs less than the physician, both because her fee is lower and because, even when she does little housework, she renders more service to the mother and the family than the physician does. Many midwives do not only the actual obstetrical work in confinement, but a large amount of housework, thus greatly assisting the mother of a family of children to get through a very trying period. This has been, and still is, a distinct element in deciding many immigrant families in favor of the midwife as against the doctor.

A good deal of evidence is accumulating, however, to the effect that the midwife is doing less housework than formerly. The head nurse of the system of supervising midwives in a large city said that the better trained the midwife was the less housework she now did. The shortage of doctors during the war undoubtedly enabled many midwives to reduce the amount of their housework and not lose clientele.

¹ See "The Midwife in England," by Miss Carolyn Van Blarcom, and "Schools for Midwives," by Dr. S. Josephine Baker, in the *Proceedings of the Second Annual Meeting (1911) of the American Association for the Study and Prevention of Infant Mortality*, p. 232, seq.

THE MIDWIFE

The material gathered by the Association for the Improvement of the Condition of the Poor, covering the period 1912 to 1919, shows this tendency over a longer period, and adds considerable weight to the belief that the housework done by the midwife is decreasing. Of two hundred and eighty-nine cases having midwives, 96.2 per cent of the midwives did not do any housework.

Midwives' fees are invariably lower than doctors'. The Detroit Maternity Survey, already mentioned, found that

. . . in the cases in which the doctor employs a practical nurse to visit his maternity patients he, as a rule, makes but one visit. The nurse makes on an average of six, and the common charge for the combined services is \$20. The patient in such cases is left to the care of a child or a neighbor for the greater part of the time. The neighbor is often paid. Midwives' charges ranged from \$7 to \$10 for services at the birth and visits daily for five days or more. A few cases are recorded in which the charge was but \$5. In the majority of cases the charge was \$10. Doctors' charges ranged from \$10 to \$30. The higher figure was not as frequently found as was the charge of \$15. Twenty-dollar or \$25 fees to doctors were found in most cases.¹

In California rates for midwives are found to be higher than in Detroit, but in California medical fees are also higher. Dr. Adelaide Brown, in a report² dated 1915, found that

¹ "How Two Thousand Detroit Mothers Were Cared for in Childbirth," Detroit Home Nursing Association, Detroit, 1917, p. 12.

² Dr. Adelaide Brown, "A Report of the Midwife Situation in San Francisco and Alameda Counties, California," with supplemental report by Mrs. Elwyn Stebbins, *Sixth Annual Report of American Association for Study and Prevention of Infant Mortality*, pp. 147-150.

IMMIGRANT HEALTH AND COMMUNITY

. . . the average fee [was] \$15 to \$20, some taking \$10 when they cannot get \$20 or \$15. . . . Of 33 midwives in the 1913-14 list registering 80 per cent of births recorded by midwives, only 13 record over 30 [births] each at \$15 apiece. Thirty births give an annual income of \$540, and \$416 (\$8 a week) is considered the minimum wage.

The fee included daily nursing care for mother and child for from ten to fourteen days.

The Association for the Improvement of the Condition of the Poor in New York City made a tabulation of two hundred and eighty-five deliveries of Italian women during the years 1912-19.¹ From their data the following table was constructed:

TABLE XXVII

FEE RATES FOR DELIVERY OF 285 CASES, NEW YORK CITY,
1912-19

CHARGES	NUMBER OF CASES DELIVERED BY		
	Midwives	Doctors	Midwife and Doctor
\$ 1-\$5.....	7	1	..
5.....	49	2	..
6.....	25	..	..
7.....	16	..	..
8.....	54	..	..
9.....	1	..	..
10.....	81	4	..
11.....	2	..	..
12.....	4	..	..
13.....	3	..	..
15.....	2	1	..
Over \$15.....	..	2	3
Free.....	20	6	2
Total.....	264	16	5

¹ Data furnished by the Association for the Improvement of the Condition of the Poor.

THE MIDWIFE

Information kindly furnished by Dr. S. Josephine Baker, Director of the Bureau of Child Hygiene of the New York City Department of Health, substantiates these figures. The data show that midwives' rates vary between \$5 and \$25. Differences appear in different parts of the city, the rate becoming somewhat higher as we proceed "uptown" in Manhattan. The great bulk of the midwives in Manhattan charge \$10. In the Bronx and Richmond, \$15 is a more frequent charge than \$10, but more than \$15 is charged in only a small proportion of cases anywhere.

Of course many immigrant families get along in this country and improve their financial status. When there is not the urgent economic handicap, they want and secure for themselves and their families the best care and attention in time of sickness that is available. Whether this can be secured through the midwife is the question. But since the midwife is not only preferred by a considerable proportion of our population because of tradition and training, but is often the only agency economically possible, she is inevitably influencing the health and future of many young Americans.

STATUS OF THE AMERICAN MIDWIFE

Midwifery in America is at present sadly unstandardized. The best type of midwife is the woman who received her training abroad and who takes up the work as a definite vocation. We also find many examples of the casual midwife, the woman who has had no training except experience with her own and

IMMIGRANT HEALTH AND COMMUNITY

her neighbors' children. When her family of youngsters have grown old enough for her to leave them she gives part of her time to helping her neighbors, and earns a certain amount of money at the same time.

Although several states, such as New Jersey, Ohio, and Wisconsin, require midwives by law to be trained before obtaining licenses, none of them has any recognized school for teaching midwifery. A large number of commercial schools exist whose advertisements may be found in not a few foreign-language newspapers. Most of these appear to give wholly inadequate training and some are undoubtedly mere diploma mills.

The Bellevue Hospital School of Midwifery, in New York, is the only school in this country under public control, which is in this case municipal. This school is under the direction of the Superintendent of Nurses. No special requirements are necessary for entrance. The applicant must be twenty-one years of age, be able to read and write, and be of good moral character. No fee is charged for the course of eight months, during which the students live in the school. There are nineteen beds for maternity cases, as well as an out-patient department. Each pupil must have attended one hundred cases, and herself conducted twenty confinements, before receiving her certificate. Up to the time of writing (1919) no graduate nurses have taken the course in the Bellevue Hospital training school for midwives. The superintendent says:

We have not yet anything in our course to induce trained nurses to enter the school. The course is too simple.

THE MIDWIFE

The number of graduates from this school was only about twenty-eight in 1918-19. Such, at present, is the status of training for midwifery in the United States of America.

The legal and social status of the midwife is very different in this country and abroad.¹ In the United States the midwife has been a declassed person. We have, in general, provided no laws regarding her training, licensing, or regulation. Consequently any woman, whether trained or ignorant, conscientious or unscrupulous, may take up midwifery.

Only recently have we begun to recognize the midwife in an official way. Only twenty-one of our forty-eight states have laws regulating midwifery, but in many of these the laws are almost valueless because no provision for enforcement is made. In Massachusetts and Nebraska the midwife cannot practice legally. In thirteen states there are no laws applying at all, and the midwife may practice for weal or woe. They are Arizona, Arkansas, Florida, Georgia, Idaho, Kentucky, Maine, Mississippi, New Mexico, South Carolina, Tennessee, Vermont, West Virginia. In twelve states the midwife is legally recognized, but there are no general laws regulating her training or practice. They are Alabama, California, Delaware, Michigan, New Hampshire, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Virginia.

In thirteen of the twenty-one states having midwife regulations, as well as in the District of Colum-

¹ We owe to the courtesy of Miss Carolyn C. Van Blarcom these data regarding state and municipal legislation on midwifery, revised up through the year 1916.

IMMIGRANT HEALTH AND COMMUNITY

bia, midwives must pass an examination before receiving a state license, but in seven of these the provision for enforcement is so poor as to make the law of no effect. The thirteen are Connecticut, Illinois, Indiana, Louisiana, Maryland, Minnesota, Missouri, New Jersey, New York, Ohio, Utah, Wisconsin, Wyoming.

Candidates for state licenses are generally examined by the state boards of midwifery, appointed by state boards of health, or by boards of medical supervision. Midwives already practicing usually can continue to do so just by registering.

The Illinois state law has a strong penalty clause covering the midwives who fail in reporting babies with sore eyes. It imposes a fine of \$100 for the first case and \$200 for the second case, or six months' imprisonment, or both.

In Omaha, Nebraska, we find that 25 per cent of all births registered are midwife cases. Under the laws of Nebraska a midwife may be prosecuted for practicing medicine without a doctor's license, but there is a city ordinance governing the Omaha situation. In a number of cities we find midwives practicing under local ordinances. Buffalo was the first city to enact such a law some forty-three years ago. Los Angeles, in 1910, passed a law by which midwives are examined and licensed by the city Department of Health.

Virginia is one of the twelve states with no general laws, but the city of Norfolk regulates midwives under an ordinance of 1912. In Norfolk a midwife is required to register and be licensed by the Board of Health, and to notify it within ten days of any

THE MIDWIFE

change in address, yet there is no penalty clause providing for failure to comply with the law. In Tennessee, another state with no law, Memphis is working under a city ordinance of August 9, 1910, by which midwives are licensed and registered. The license is good for one year and can be renewed annually. Memphis invokes a fine of from \$5 to \$50 for midwives found practicing without a license.

The system of supervision of midwives in the city of Newark, New Jersey, may be briefly described as one of the excellent examples of the best type of work.¹ New Jersey has a compulsory law, but the following experience indicates how much farther co-operative efforts with midwives will go than mere legal pressure.

When our bureau was organized in 1913 to protect the health and prevent disease and death in mothers and infants we recognized that the active supervision and training of midwives was one of the most effective methods of obtaining this result, since the midwives in Newark attend 50 per cent of the births and in certain groups of nationalities as high as 80 per cent and 90 per cent.

In the beginning we directed our attention to interesting the midwife in the work we were undertaking for the protection of maternal and infant life in the belief that midwives would respond to the appeal as well as other members of the community. The midwives were asked to assist the nurses in their districts: firstly, by reporting promptly all the births; secondly, by establishing the routine of infant care and breast feeding, which would later be taught by the nurse when she visited the mother; thirdly, to advise the mother that the nurse would visit and that she should welcome and accept the instructions that were to be given to her. In this way we capitalize the influence

¹ Dr. Julius Levy of Newark, New Jersey, memorandum for this study.

IMMIGRANT HEALTH AND COMMUNITY

the midwives had with the foreign-born mothers and at the same time removed the initial suspicion that the Health Department desired to interfere with their practice and eventually to eliminate them entirely. A booklet was printed in the various languages spoken by midwives, which set forth not only the legal restrictions on the practice of midwives, but amplified these laws so that they could not plead a lack of understanding of the law for any infraction of it.

I may illustrate this point, which I consider a very important factor in obtaining results, by referring to the regulations which prohibit midwives from assuming care of abnormal cases. Most midwives do not consider conditions abnormal that are at all frequent or that they feel themselves competent to look after. By this method we have gradually trained the midwives to consider all conditions that we think require special medical attention as abnormal, even such as difficult maternal nursing, or the care of an immature infant.

Later we adopted the practice of inviting each midwife for a special interview whenever the nurse discovered any condition or heard of any practice that indicated either carelessness, ignorance, or excessive activity or officiousness.

This gave us an opportunity to explain to each midwife individually the importance of reporting all births and reporting them promptly within the five-day limit, of sending for doctors promptly whenever there was the least abnormality in pregnancy or labor or infant, of explaining the proper technique for the care of mother and infant.

We have investigated every case of puerperal death to determine if a midwife attended it at any time. In each instance the midwife was asked to appear before us so that we might be able to point out the care that should be taken to prevent a similar fatality, even though there was no evidence that the midwife was responsible.

In the beginning we did not attempt to fix responsibility upon the midwife, but rather gave her the impression that while we believed all she said in regard to her extreme precautions and aseptic technique, the particular death

THE MIDWIFE

showed the necessity of even greater care and precautions. This same method has been followed out in obtaining reports of ophthalmia, the use of silver nitrate, prompt reporting of births, care of nipples and breasts, and the prevention of unnecessary weaning.

Even when our reports showed that the midwives were using hypodermic injections of pituitrin, arsenic, and strychnine we took the position that inasmuch as heretofore no public department has taken any interest in the work or exercised any supervision, it was only fair that they be given a chance to adjust themselves to the new conditions and that the best results would be obtained by getting the midwives to discontinue this practice through the proper spirit of co-operation and appreciation of the dangers of this practice to the patient and to the midwife herself, rather than by proceeding against her legally.

When we discovered that a certain few midwives persisted in this type of practice after having been warned several times they were brought up on charges before the courts, and in several instances fined in accordance with our city ordinance.

A lecture course was arranged which was given by the representative physicians of the city on obstetrical work and the care of babies. Demonstrations of the preparation of the bed, the patient, and the room have been given at the City Hospital by the instructor of the training school.

The effect of supervision in Newark is well brought out, perhaps, by the statement that has been made by our county supervisor of midwives, who learned that midwives who carefully conformed to the best standards of midwifery practice and legal regulations while working in Newark would frequently become neglectful or assume risks when their patients lived outside of Newark.

The training and supervision of midwives, not mere legal regulations and policing, have contributed in no small way to the very gratifying results in child hygiene in Newark, where, with a very small appropriation, \$20,000, it has been possible to bring the infant mortality rate for the first six

IMMIGRANT HEALTH AND COMMUNITY

months of 1919 to 77.6, the second lowest rate for the fourteen largest cities in the United States.

If such supervision is well conducted, it tends to encourage good midwife practice, whereas an attempt to ban midwives by legislative fiat keeps the best ones out of the state, as in Massachusetts, and leaves the practice chiefly to the ill-trained and unscrupulous, who work in spite of the law.

QUALITY OF AMERICAN MIDWIFERY

The quality of the midwife's work may be judged in comparison with an ideal standard or with other forms of obstetrical care available to the poor. Naturally, those who have looked at the midwife from the top down, and those who have looked at her from the bottom up, are likely to disagree as to the reality. Some have judged her by the standard of obstetrical service actually maintained by specialists in the homes of their patients, or by maternity hospitals of the first class. For instance, Doctors Emmons and Huntington, in their vigorous attack on the midwife,¹ compare her work with "the minimum amount of care which, in the light of modern medicine, it is fair, right, and humane to offer."

Few have been ready to compare the work of the average private physician with the same standard. It is well that this is not done, for the comparison is fair to neither midwife nor physician. Neither is

¹ A. B. Emmons, 2d, M.D., and J. L. Huntington, M.D., "Has the Trained and Supervised Midwife Made Good?" *Proceedings of Second Annual Meeting (1911) of American Association for the Study and Prevention of Infant Mortality*, pp. 199-213.

THE MIDWIFE

provided with the facilities, financial or professional, which the highly paid specialist has at his command in the homes of the wealthy or in well-organized maternity hospitals and out-patient services. Comparing the actual results of midwifery with the sum total of obstetrical practice, the midwife has been shown to be doing a relatively good grade of work.

This point of view is amply expressed, both in correspondence carried on during the study and in published material. A nurse of high standing, occupying an important supervisory position in a large industrial center of the East, speaks as follows:

At present the midwives are teaching me. Many of them are well-educated, thoroughly trained women. The Italian midwife is an unusually well-educated woman, ranking next to the priest in many Italian communities. In Italy none but a well-educated woman can qualify for the training, which covers from two to four years. The Italian midwife is a splendid woman, with a fine viewpoint, and desires to be of service. They are well-trained, scientific women, recognizing the value of inspection and supervision, to which they have always been accustomed in Italy, and welcoming it when they find it in America. They are so thoroughly well trained and taught that never under any circumstances will they try to handle unusual conditions, but immediately will call in a physician.

A physician occupying a position in one of the largest state departments of health in the country writes:

I have observed good and adequate care rendered by midwives. Many of them have been trained in the great schools abroad, and these women are very expert and do excellent work. Several midwives under our supervision

IMMIGRANT HEALTH AND COMMUNITY

have undergone periods of training as high as four years abroad, including such training as would be equivalent to, if not better than, some received by some American nurses. Of course the variety of ability on the part of the midwives varies from such skilled service to what is doubtless only very superficial ability.

A well-known physician ¹ in charge of an important bureau in a city department of health furnishes a statement of interest in this connection:

We have been supervising our midwives for four years, during which time they have handled from 5,414 to 5,696 births per year. Thirty per cent of all midwives are German, 21 per cent Italian, 21 per cent Austrian, and the remainder Russian, Polish, and Armenian. If the midwife is the cause of much infant mortality we should have a high infant mortality rate, for 50 per cent of all births and 88 per cent of all foreign-born mothers are attended by midwives. The maternal mortality in our city among midwife cases is no higher than in the city, as a whole. In order to get exact data we followed up until one month after birth 586 mothers delivered by midwives, and in this group one mother died. When we recall that midwives attend as much as 88 per cent of our foreign-born groups living in congested quarters there seems to be little ground for the charge of high maternal mortality among the women in our city.

An article by Dr. Charles V. Chapin,² recently published by the Federal Children's Bureau, says:

Last year 10 per cent of physicians' reports were late and only 1 per cent of the midwives'. . . . No wonder that in Providence, in 1917, the infant mortality rate of midwives' babies was 77, while of all others it was 117. It cannot be argued that this is because the midwives care

¹ Dr. Julius Levy of Newark, New Jersey.

² Dr. Charles V. Chapin, "The Control of Midwifery," *Standards of Child Welfare*, Children's Bureau, 1919, pp. 157-160.

THE MIDWIFE

for a stronger stock of women and healthier babies. About 85 per cent of the midwives' babies are of Italian mothers. In the years 1902-09, before there was any instructive nursing service for mothers, the infant mortality rate among Italians was 138. In 1917 it was 93.

Under control . . . midwives are not dangerous to the babies, as is shown by the Providence figures. . . . That they are not dangerous to the mother is indicated by data from Philadelphia, where there were only 17 deaths in about 12,000 confinements attended by supervised midwives.

A similar opinion of the midwife comes from the Department of Health of Newark, New Jersey:¹

The results obtained from prenatal supervision of mothers (by the Division of Child Hygiene) has been particularly satisfactory. . . . The division has continued its policy of supervising the midwives in the city and has received very hearty co-operation from the midwives themselves. There is no doubt that they are sending for physicians more frequently in difficult labors and are advising the mothers more properly in the care of the infants in most instances.

From a study of maternal and infant mortality among mothers attended by midwives it would appear that the results are very commendable. We investigated forty-one puerperal deaths reported by physicians to determine if there was any foundation for the impression that puerperal deaths that occurred in the hospitals or in the practice of physicians are often the result of midwifery incompetence, ignorance, and neglect, the cases being referred, it is claimed, to hospitals and physicians when all the mischief has been done. Of the forty-one cases it developed that in only ten had a midwife been in attendance at any time, and in no instance did the doctor claim that the midwife was in any way responsible for the result.

The maternal death rate in Newark is one of the lowest

¹ *Annual Report of the Department of Health, Newark, New Jersey, 1917, pp. 152-153.*

IMMIGRANT HEALTH AND COMMUNITY

in the large cities of the United States, although midwives attend 50 per cent of the births of the city. . . . The infant mortality is lowest among the babies whose mothers are attended by midwives (as the following table shows):

TABLE XXVIII

DEATH RATES PER 1,000 BIRTHS FOR INFANTS ATTENDED AT BIRTH
BY MIDWIVES, PHYSICIANS, AND HOSPITALS, 1915-16-17

CASES DELIVERED	RATES
By midwives.....	71.2
By physicians.....	80.4
In hospitals.....	91.0

' In considering this fact it should be pointed out that the midwives attend a smaller proportion of primipara (first births) than physicians or hospitals.

Dr. Abraham Jacobi,¹ in an address as president of the American Medical Association, declared:

The results of midwife practice do not always compare unfavorably with those of our professional brethren. Of 116 cases of ophthalmia neonatorum which were treated in the Massachusetts Eye and Ear Infirmary in one year, 114 were in infants attended by physicians, and two by midwives. Of 33 cases treated in the New York Eye and Ear Infirmary in one winter 22 occurred in the practice of physicians and 11 in that of midwives. Of the 11 midwives, 3 had used nitrate of silver; of the 22 doctors, only 1. According to these reports, if it were wise and proper to generalize, the doctors should be replaced by midwives.

Dr. J. Whitridge Williams, in an authoritative survey of the teaching and practice of obstetrics in

¹ Dr. Abraham Jacobi, "The Best Means of Combating Infant Mortality," *Journal of the American Medical Association*, June 8, 1912, pp. 1740-1744.

THE MIDWIFE

the United States in 1910, asked the teachers of obstetrics in the medical schools of the country a number of questions. Among them was the following, which is quoted with its answer and with Doctor Williams's summary.¹

Do you believe that more women die from puerperal infection and eclampsia in the practice of midwives or of general practitioners?

To this 8 teachers replied that they did not possess sufficient data upon which to base an opinion; while of the 35 who answered, 17 stated physicians and 13 midwives, while 5 held that their death rate is about equal.

Accordingly, it appears that the majority of teachers in this country consider that general practitioners lose as many and possibly more women from puerperal infection than do midwives. This is an appalling conclusion, as it is generally believed that infection is the main cause of preventable deaths in the practice of the latter. It may, however, be mitigated to some extent by admitting that the more serious cases of infection occurring in the hands of midwives are eventually seen by physicians, so that their death is not credited to the former; but even after making such allowances, it is impossible to escape the conclusion that such a condition of affairs is a railing indictment of the average general practitioner and of our methods of obstetrical instruction.

The conclusion reached by Doctor Williams does not seem to have been shaken by subsequent investigations or criticisms. Our interest, however, is much less in making a comparison between the midwife and the medical practitioner than in considering the midwife herself, as an agent of maternity service

¹ J. Whitridge Williams, M.D., "The Midwife Problem and Medical Education in the United States," *Report of Second Annual Meeting, American Association for Study and Prevention of Infant Mortality*, 1911, pp. 165-194.

IMMIGRANT HEALTH AND COMMUNITY

to foreign-born mothers in this country. The conclusions reached as a result of practical experience by departments of health, physicians, and nurses, are not arguments that we should be satisfied with the midwife as the means of obstetrical service for the people, whether foreign or native born. They are evidence that competent professional men and women who have had actual experience rate the work of certain types of midwives as of excellent grade.

An impartial look at the midwife situation brings out some important facts. It must be recognized that our knowledge of midwifery in the United States is limited. Statements from the many communities in which there is no official regulation and supervision of midwives cannot represent the whole situation.

The facts reported from communities in which midwives are regulated and supervised, and in which, therefore, the whole body of midwife work is more or less well known, demonstrate that a certain proportion of midwives provide at least as good care as any other which the mass of the people can pay for on a business basis. On the other hand, there is a certain proportion of midwives whose work is below any acceptable standard.

While we cannot, therefore, make a sweeping judgment either way of the quality of midwives' work, we can point out certain intrinsic limitations that will prevent her from ever being a wholly satisfactory instrument of maternity care.

Most important, the midwife cannot herself provide certain elements essential to a good standard of maternity care. She cannot furnish expert obstetri-

THE MIDWIFE

cal diagnosis, nor give expert supervision and advice during pregnancy, nor provide for obstetrical emergencies at the time of confinement.

This difficulty might be overcome if the midwives could be made part of a system in which their deficiencies were supplied by the work of expert obstetricians; but it would be impossible so to organize the midwives who are practicing in this country to-day, owing to their wide variations in quality. Much of midwifery is casual work, taken up by women who have had little training except experience with their own or their neighbors' children. The work of these women is usually of an impossibly low grade. Real supervision and the maintenance of a high standard would keep the best within the system and eliminate the worst of those who now practice midwifery, but the number left would not be adequate for the work, and in order to recruit new midwives of the grade of those who have come from Europe, the status of the profession must be raised materially.

XI

ADEQUATE MATERNITY CARE

WHILE it is true that the newest immigrants turn to the midwife automatically, there is some evidence that with longer residence in this country the foreign born naturally forsake the midwife.

In the article previously quoted, Dr. Charles V. Chapin said:

There is evidence to show that midwifery is decreasing. Doctor Woodward stated that in the District of Columbia between 1896, the date of the adoption of the law regulating midwives, and 1915 the number of births attended by midwives in the District of Columbia fell from 50 per cent of the total births to less than 10 per cent. In 1918 it was 5.5 per cent. This was due chiefly to the elimination of midwives by examination. In New York, in 1905, 42.1 per cent of all births were attended by midwives, while in 1917 the per cent was 33.5. The decrease has been especially rapid since the opening of the war, which is interpreted as indicating that it is the newcomers who are most inclined to rely upon the midwife. In Providence the proportion of births attended by midwives increased with the increasing tide of Italian immigration up to 1913, when more than 33 per cent of all births were attended by them. In 1918 the percentage was 27.5. In Providence there has been an almost complete disappearance of the Jewish midwife. Ten years ago nearly 150 births annually were attended by Jewish midwives. Last year there were but 4 so attended, although we have a Jewish population of nearly 20,000. This seems to be due largely to the appreciation on the part

ADEQUATE MATERNITY CARE

of Jewish women of the value of medical service. In Rochester the number of midwives and the number of births attended by them has decreased during the last eight or ten years.

If we would hasten the displacement of the present midwife's practice, we must provide substitutes that will be understood by and acceptable to the people who now use midwives most extensively. To overcome the traditional reason for selecting the midwife, and the so-called sex prejudice against a man doctor, is a matter of education. The economic reason for using the midwife cannot be directly overcome by education, although people will often pay more if they feel sure that by so doing they will get something much better. So many of our immigrant families live under severe economic pressure, where every dime must count, that a new maternity service cannot cost much more than the midwife if it is to be readily used, and at least as much convenience to the family at the time of confinement is to be assured.

When the immigrant looks about for a substitute for the midwife, he finds the private physician and certain organized medical resources—the maternity hospital, the out-patient system of maternity care, and various clinics. The Maternity Center Association of New York estimated that in the year 1917, midwives cared for about 40 per cent of the total number of births in the entire city; that about 30 per cent were cared for by the out-patient system of maternity care, plus the maternity hospitals themselves—that is, by an organized maternity care system. The remaining 30 per cent of confinements

IMMIGRANT HEALTH AND COMMUNITY

were cared for by private physicians. The proportion¹ of cases receiving care through an organized system of hospital and maternity out-patient departments is larger in New York City than perhaps anywhere else in the country.

In most communities the only available substitute for the midwife at the present time is the private doctor. We have seen some of the reasons why many immigrant families will employ a private doctor at the time of the mother's confinement only with reluctance, or only in an emergency.

The doctor often does not speak the language of the family. He charges more; he renders less service. Does he give better service from the point of view of the immigrant family? A Jewish woman said to an American visitor, speaking of the doctor and the midwife: "The doctor, even the professor doctor, he comes to your house to get your baby. He hurries you up; he hurries you up; he hurries you up, and that is not so good." What Dr. Whitridge Williams says in the article quoted in the last chapter about the inadequate teaching of obstetrics and the inadequate training of the average practitioner for this work, is not known by the immigrant mother, but she and her friends have felt some of its results. If the fee that they pay the doctor is so low that he can or will give them only very little time, and hurries them up, and uses forceps to take the baby, they may make a comparison with what the midwife will do for them to the advantage of the latter. Not a few immigrant families who have been interviewed give exactly this testimony, expressed in their own way and not in technical terms.

ADEQUATE MATERNITY CARE

Facts of this kind are not a criticism of the medical profession as an agent of maternity care. They are a substantiation of the statements of Doctor Williams and other leading physicians as to the inadequate training in obstetrics which many physicians now in practice received during their medical school days, and the inadequate training which many medical schools even now provide.

If, through various means, the amount of obstetrical practice brought upon the rank and file of practitioners were increased, it would tend to increase the fee rates and also the haste on the physician's part which is now one of the chief evils in obstetrical practice. So large an amount of the practice of obstetrics among the foreign born is now in the hands of midwives that the medical profession has everything to gain by seeing that suitable substitutes for the midwife are provided under real medical supervision. The impossibility of the private physician acting at this time as this substitute for the masses of the foreign born should be frankly recognized.

An adequate substitute for part of the midwife's service, supervision, and nursing care before and after confinement, is provided by public maternity clinics.

THE PRENATAL CLINIC

Prenatal clinics are now established in many cities under the auspices of private organizations or departments of health, as centers to which pregnant women may come for examination and advice, whether these women employ their own physicians

IMMIGRANT HEALTH AND COMMUNITY

or go to an organized teaching system for maternity care. The advantages of obstetrical diagnosis and of supervision and education by the nurse in the woman's home during pregnancy and the post-partum period, can be provided irrespective of the care at confinement.

One of the great limitations upon the extension of this system has been that many private physicians have been unfamiliar with the prenatal clinic or with its benefits. Others have been unwilling to make use of it because they regarded it as an interference with their practice. For these and other reasons prenatal clinics have made little headway in persuading the private practitioner to send his patients to them for examination and for nursing service.

In several cities in which a system of supervising the midwife has been well worked out, the prenatal clinics play an important part in this connection. The nurses are in contact with the midwives, the midwives bring their cases to the clinic for consultation, and so the system of clinics with nursing service not only assists the mother, but makes the supervision of the midwives more efficient. It tends to help the better midwives and to drive out the poorer.

Since midwives are so predominant a factor in maternity care among the foreign born, it is of the first importance that prenatal clinics, maternity hospitals, and other facilities for good maternity care shall make a special effort to work with them. Some maternity hospitals have developed social-service departments, which make a special effort to do this, but they seem to have made only a limited contribu-

ADEQUATE MATERNITY CARE

tion to the technique of dealing with the foreign born.

MATERNITY CENTER ASSOCIATION OF NEW YORK

The Maternity Center Association of New York has devoted special attention to immigrants in planning its service, and its experience and methods may be described as a suggestion for other organizations, private and public. This organization dealt with some seventy-five hundred maternity cases during one recent year, at least 75 per cent of the mothers being foreign born. The association divides the city into zones. There is, or there is to be, a maternity center for each zone. Each zone has a subcenter known as a station. Each station has a weekly clinic. In order to overcome one feeling or "prejudice" of many foreign-born mothers, the clinics are conducted by women physicians. The nurse at each station holds daily office hours, where mothers from anywhere in that district may come for consultation.

The nurse carries on prenatal work in the homes, visiting expectant mothers once every two weeks "if the patient is normally well," up to the seventh month, and weekly after that. During the entire time the nurse keeps careful record of the woman's condition and brings her into the clinic if there is any suspicion of trouble.

The maternity nurse of the center does no bedside nursing, but arranges with another organization for this kind of care. The nurse visiting the home of the patient is supposed to make an analysis of the environment in which her patient lives and to correct

IMMIGRANT HEALTH AND COMMUNITY

any environmental defects, since the mother's mental condition is as important as her physical condition, or is a part of it. The nurse helps to make arrangements for care at delivery and to secure hospital care if it is desired.

The patient is supposed to send word to the maternity station when she goes into the hospital, or to notify the nurse when delivery is expected, so that she can arrange for nursing care at home.

The Maternity Center Association considers maternity and prenatal work as a teaching proposition, and one afternoon a week the nurse has a demonstration lesson at the station where she instructs mothers (using a life-size baby doll) in the care of a baby, shows the proper layette, and so forth. One week the nurse gives this instruction or demonstration to the mothers; the following week the mothers show the nurse the proper way to do it. The nurse has patterns and shows them how to make the baby's clothes, how to make maternity clothes, or how to alter their own to meet the emergency.

The doctors and nurses appointed to the work are chosen for special qualifications: Public health and maternity experience, understanding and experience in handling foreign groups, in many cases knowledge of the foreign language—all being considered. Ignorance of a foreign language, however, is not an absolute bar to the engagement of a nurse, as interpreters can always be found and thoroughly competent, sympathetic, and experienced nurses cannot. This association is the only one of all those with whom we have been in touch which insists that its local station, doing prenatal or similar work, must have

ADEQUATE MATERNITY CARE

either a paid interpreter or a doctor and nurse, both of whom speak the language or languages necessary.

The nurses co-operate with the midwives in their districts and report to them as to the condition of their cases, just as they do to physicians. Midwives are said frequently to report the names and addresses of women who have engaged them for their coming confinement. The nurses visit the midwife's cases as they do those referred by a physician.

The neighborhood response to the activities of the maternity centers thus conducted, seems to show that the plan of work makes itself known to the foreign-born mothers of the district and calls forth a rapidly increasing utilization of the service offered. The Maternity Center Association of New York is emphasizing the adaptation of its prenatal and maternity service to immigrants in a manner which should render its work of great interest to departments of health and private organizations throughout the country. The prenatal clinics supplement the work of the obstetrician, but since they do not provide for the actual delivery they cannot supplant the midwife.

MATERNITY SERVICE BY MEDICAL SCHOOLS

The only important substitute for the midwife which has been thus far developed on an extensive scale is the organized maternity service connected with the medical school, including a hospital and an out-patient system of care. This system is extraordinarily little known to the general public. Medical students must be taught obstetrics in some fashion,

IMMIGRANT HEALTH AND COMMUNITY

and the best medical schools throughout the country have developed a maternity service, partly for this purpose and partly to benefit the mothers of the community who cannot afford to pay for private obstetrical care. When thoroughly developed, the system includes the following elements:

1. A maternity hospital, which may have paying and part-paying beds as well as free beds.

2. One or more "prenatal" or "antepartum" or "pregnancy" clinics, as they are variously called. One of these may be located at the hospital itself, and others in various parts of the city. At each of these clinics there is, at regular intervals, a physician well trained in obstetrics, with the necessary equipment and nursing service to make examinations of pregnant women.

3. A visiting-nurse service, conducted either by an outside district nursing organization or by the institution itself, for visiting patients in their homes during pregnancy (the so-called prenatal work), for attendance after delivery, sometimes for giving care at confinement, in the home.

4. The medical student who, under certain important restrictions and under supervision, delivers patients in their homes.

The operation of such a system has been succinctly described in a recent article, which may be quoted:¹

The patient presents herself at the clinic. She is examined carefully and thoroughly. She is visited at her

¹Stephen Rushmore, M.D., and Alonzo K. Paine, M.D., "A Suggestion for the Improvement of Obstetrics," *Boston Medical and Surgical Journal*, November 20, 1919, pp. 615-618.

ADEQUATE MATERNITY CARE



DEVELOPMENT NEEDED IN MATERNITY CARE

home by the nurse, who sees that everything needed at confinement is in the house. She visits the clinic for further examination and advice. When she falls into labor word is sent to the hospital and her record is reviewed.

IMMIGRANT HEALTH AND COMMUNITY

Attendants from the hospital, usually two undergraduate medical students, go to her home, sometimes accompanied by a nurse. Reports are sent to the physician at the hospital, on printed forms covering all important points to be noted in the patient's condition. Preparations are made for delivery, and if labor is not progressing satisfactorily the patient is seen at once by the resident physician. If necessary, the patient is transferred to the hospital or a member of the visiting staff is called so that the patient gets adequate care throughout.

The resident physician at the hospital knows the patient's condition and the progress of the labor through the frequent reports sent to him. He goes to her when he is needed and when he leaves she is in the hands of competent observers who can send for him when necessary. Following the confinement at the house there are visits by the doctor, the medical students, and the nurse until the patient is discharged.

There are several essential points of such an organized system of maternity care. Obstetrical diagnosis is desirable as early in pregnancy as possible. This means determining whether the woman can bear a child normally or whether she has some difficulty, such as a malformation of the pelvis, which would require special care or a surgical operation in the hospital.

Supervision and instruction during pregnancy is a desirable feature. This means periodical visits of the nurse to the mother's home to teach her to care for herself and to prepare for the coming child. Medical conditions must be watched during pregnancy, so the mother comes to the prenatal clinics for further examination by the obstetrician; periodical tests of urine, and so forth, are regularly made.

ADEQUATE MATERNITY CARE

Delivery is under supervision. The medical student is allowed to deliver a case only under certain conditions, and must pass the responsibility to a graduate physician specially skilled in obstetrics, whenever specified conditions arise. Furthermore, the preliminary diagnosis and supervision of the patient have eliminated all those pathological or abnormal cases which could be foreseen.

Obstetrical emergencies are met either by determining them in advance and arranging for the delivery of the woman in the hospital, or when the emergency is unforeseen, by calling the resident or visiting physician, precisely that degree of skill being applied to each case which the case actually requires. The normal delivery of the woman who has already borne children almost takes care of itself, while an obstetrical emergency may require the highest degree of medical judgment and skill to save the mother and baby.

Postpartum care is given through nursing service in the home, and medical supervision is continued during the whole puerperal period. One of the most important parts of the system is the education of the mother of the family in both care during pregnancy and care of the baby after it is born.

The results of these systems of organized maternity service have been astonishingly good. In the outpatient service of the Boston Lying-In Hospital, students of the Harvard Medical School have year after year delivered 2,000 cases or so, with none or very few deaths. In Chicago the Lying-in Hospital, during nineteen years of operation, has cared for 24,764 confinements, with only eight maternal deaths

IMMIGRANT HEALTH AND COMMUNITY

among the patients who were exclusively under its care.

The contrast between these almost vanishing maternal death rates and the maternal death rate of about 5 to 1,000 in the United States as a whole, is due at bottom to the system of supervision. The care of the woman at confinement is fortunately a comparatively simple thing in the large majority of cases, but in a minority of cases the problem is difficult, often extremely difficult. The emergencies, when they occur, are grave, urgently threatening two lives. Some of these difficulties and emergencies can be foreseen and provided for in advance, so that they will not occur at all. A certain small proportion cannot be foreseen, and when these arise just that degree of skill and equipment which can cope with them successfully must be promptly on hand. Neither the unregulated midwife nor the general practitioner working alone in the patient's home can meet these requirements.

These systems have been largely taken advantage of by the foreign born. In Boston something like 3,000 cases a year are delivered in their homes or in the maternity hospitals through the teaching and hospital services connected with the Harvard and the Tufts Medical Schools. A large proportion of these cases are Jewish or Italian. The clientele of the Chicago Lying-In Hospital is largely Jewish and includes a considerable number from other foreign-born groups. In New York the same is true. The following figures from the study by Dr. Lewinski-Corwin, previously mentioned, make an interesting comparison between races:

ADEQUATE MATERNITY CARE

TABLE XXIX

THE KINDS OF MATERNITY CARE SECURED BY PATIENTS OF VARIOUS
RACES IN NEW YORK, 1903-18
(Testimony secured from mothers during block canvass)

RACE	TOTAL NUMBER CASES	NUMBER DELIVERED BY ORGANIZED MEDICAL CARE IN HOSPITAL OR IN HOME	PERCENT- AGE SO DELIVERED
Slavs.....	311	8	2.6
Italians.....	406	10	2.5
Jews.....	213	64	30.0
Native born.....	190	47	24.7

The cheapness of the maternity care offered by these organized systems is one of their great advantages. The medical students do the work for nothing. So do the visiting obstetricians. The resident physicians, who stand between the students and the visiting staff, generally receive nominal or moderate salaries, as they are securing valuable special experience. The only expenses to be met are for overhead, upkeep of the plants, and home-nursing service. Many of the patients can pay enough to cover a considerable porportion of these expenses, and some of them can pay enough to cover all. Consequently, the service can be, and is, offered at nominal rates, and the home deliveries are usually provided free when necessary.

The only obstacle to the indefinite extension of this almost ideal system is the limited number of medical students. During the last few years the annual number of medical graduates has been about 2,500 or 2,600. Even if each of these students were to deliver 20 cases in their homes—which is a very much larger number than students deliver in most medical schools—the total number of cases delivered by all the

IMMIGRANT HEALTH AND COMMUNITY

medical students in the United States would be only about 50,000. This is about 2 per cent of the births in the United States. It is just about the number of births which occur each year in the city of Chicago.

The number of medical colleges is on the decrease rather than on the increase. There are at the present time 95 medical schools in the country, in about 60 different communities.¹ For reasons of medical teaching efficiency they tend to be in large centers of population. There were in the United States, in 1917, 272 communities of over 25,000 estimated population.² There were, according to the census of 1910, 2,173 communities of between 2,500 and 25,000. The rural area of the United States includes a little more than half the total population. The medical colleges and the medical students can develop a system and set a standard of medical care, but they can provide for only a minute fraction of the mothers of the United States in their time of need.

A PRACTICAL PLAN

The only effective maternity service thus far developed has been the out-patient teaching service, and the number that can be reached by this is limited by the number of medical schools. A practicable method of securing the advantages of this system without the use of the medical student has been suggested by Dr. A. K. Paine, as a member of the committee on

¹ According to 1918 classification of American Medical Association.

² *Department of Commerce, Bureau of the Census, Bulletin 138, Table VI.*

ADEQUATE MATERNITY CARE

Prenatal Care and Obstetrics, of Boston. We may quote from the statement made by Doctors Paine and Rushmore:¹

The scheme proposed for discussion by the committee is the substitution for the medical student of graduate and undergraduate nurses, preserving in other respects the system now in use in many hospitals.

There would then be in a municipal or other hospital an obstetrical department as a center to which all cases needing hospital care could be sent. Prenatal clinics would be established here and at substations in the district if necessary. Patients at their homes would be cared for by physicians from the hospitals, who would be assisted by nurses as they are now assisted by medical students. If transportation were provided by automobile, the number of cases seen and cared for would be greatly increased for a given amount of effort.

THE COST OF A COMMUNITY PLAN

The cost of this plan of service is important, since its field of action would be the large number of cases now covered by the midwife and the smaller, but important, number who now receive no care, or get medical charity at the hands of physicians or institutions. In their committee report, Doctors Paine and Rushmore made estimates which are worth quoting in detail.

The following items of nurses, physicians, supplies, and automobiles must be included in the cost of such a system. The estimates are on the basis of 5,000 deliveries cared for during a year:

¹ Stephen Rushmore, M.D., and Alonzo K. Paine, M.D., "A Suggestion for the Improvement of Obstetrics," *Boston Medical and Surgical Journal*, November 30, 1919, pp. 615-618.

IMMIGRANT HEALTH AND COMMUNITY

Nurses.—Needed for antepartum visits, for attendance at confinement, and for postpartum visits.

Antepartum visits.—Each patient should be visited once at her home by the nurse to see that she has made proper preparations and has the necessary supplies on hand. For normal cases no other visit is necessary, as the patient reports at the clinic for observation and examination. It is estimated that the patients needing special care, as in toxemia, bleeding, and so on, will require 3 visits each on the average, and will constitute about 5 per cent of the total number of patients. Of these patients needing special care, a considerable number will be actual in-patient cases, and will have to be transferred to the hospital. If 4 visits per patient were necessary, it would make 1,000 extra antepartum visits, making a total of 6,000 antepartum visits.

If the year be reckoned as comprising 300 nursing days, this gives 20 visits per day, which would require the whole time of 2 nurses.

Five thousand births in the course of a year gives an average for one day of 13 plus, which may be regarded as 14. Eight hours may be allowed as the average time that would have to be spent with each case. With an eight-hour day this would be 14 nurses for a day's work. If 2 nurses attended each case, 28 would be required. Of these one half would be graduate nurses, the other pupil nurses.

Postpartum visits.—Averaging a visit a day for 10 days, there would be 14 visits for the first day, increasing each day until on the tenth day there would be a maximum of 140 visits, the daily number from that time on. Postpartum visits would require an hour for each and would therefore require 18 nurses a day.

It is estimated that 5 supervisors would be required for this total of 48 nurses.

<i>Cost:</i> 14 graduate nurses and 5 supervisors at	
\$100 per month.....	\$ 1,900
34 pupil nurses (average \$42 per month) ..	1,428
Total per month.....	\$ 3,328
Total per year.....	39,936

ADEQUATE MATERNITY CARE

Physicians.—There would be a consulting or visiting staff and a resident staff, only the latter involving expense.

Probably 6 men would be necessary for the resident staff. They would be on 24-hour shifts. Thus, 3 men would be taking confinements for 24 hours, making an average of about 5 a day. For the next 24 hours these 3 men would be making postpartum visits, on the third and tenth days of the puerperium, attending to the antepartum clinics, keeping up records, and would have one undisturbed night for sleep. Each man would have one evening and afternoon off in six.

<i>Cost:</i> 6 at \$36 per month (average).....	\$ 216
per year.....	2,592

It might be well if these men were salaried and the term of service might well be a six months' service.

Supplies.—The cost of supplies would not be very great, as many of the supplies are provided by the patients, purchased under the direction of the nurse or doctor. A dollar per patient would be ample—\$5,000.

Ambulance—automobile.—In order that a physician shall be able to take care of five cases a day, on the average, and to enable nurses to attend cases promptly at any time of the day or night, in any part of the district, automobile transportation would be necessary. It is estimated that four ambulances or other automobiles would be required.

The average cost per month of one ambulance at the Boston City Hospital is \$365 (all costs, including drivers on 8-hour shifts).

<i>Cost:</i> 4 autos per month.....	\$ 1,460
per year.....	17,520
<i>Total Cost:</i> Nurses.....	\$39,936
Physicians.....	2,592
Supplies.....	5,000
Automobiles.....	17,520
	<hr/>
Total.....	\$65,048

IMMIGRANT HEALTH AND COMMUNITY

This would make an average cost per case (5,000 cases) of \$13.02. It may be that the allowance for automobile service is too generous, since less expensive machines than ambulances could be employed, except for emergency cases requiring transfer to a hospital. These are relatively few. We might safely reduce the automobile expense to \$12,500. On the other hand, the physicians' and nurses' salaries seem unduly low. In many communities the visiting staff should have fees, and the resident staff should have salaries of \$75 to \$100 per month. Ten thousand dollars should be allowed for medical salaries. The cost of hospital care for 250 cases (5 per cent of 5,000), at an average of \$50 each, would be \$12,500. Finally, overhead supervision and incidental expenses would have to be allowed for. This would be less if the maternity care system were part of a larger organization. Four thousand dollars to \$7,500 should be sufficient. The total of all would be between \$90,000 and \$100,000, or between \$18 and \$20 per case. This figure is presented more for purposes of discussion than as a substantiated estimate.

A considerable proportion of the recipients of this care could pay this amount, since they pay as much as this now to midwives. It should be considered not a charity, but a public service.

It would be essential for the successful operation of this plan that a sufficient number of the right type of women be secured as nurses and that the proper training be given. The term "midwife" must be abandoned for the term "nurse," with the prefix "maternity" or "obstetrical." "Maternity nurse" would seem to be the best title. After all, the great-

ADEQUATE MATERNITY CARE

est drawback to midwifery in this country is that which nursing faced in its "Sairy Gamp" stage. Nursing, before the time of Florence Nightingale, had many Sairy Gamps. Miss Nightingale's greatest service was so to dignify the profession, so to touch the imagination of the community—and especially

NURSE MUST RELIEVE THE DOCTOR IN CARING FOR MANY BABIES BORN

of womankind—that nursing became a vocation which could draw the finest types of womanhood. The care of the mothers of our nation at the time when they are bringing babies into the world is a worthy and inspiring service, and must be dignified

IMMIGRANT HEALTH AND COMMUNITY

as such. Then women of the fine type who have entered the ranks of nursing during recent years will enter this branch of the same profession.

Specialization within the nursing field becomes constantly more common and more important. The various branches of visiting and public health nursing, hospital or institutional nursing, teaching, and administration—all are recognized as distinct types of work which demand special training. The curriculum of the training school must be amplified, made more flexible, and relieved of routine elements unnecessary to the best nursing as such. The latter part of the nurse's course must give opportunity for specialization.

Maternity care should be regarded as one of the definite branches of nursing, for which a certain number of those entering the profession should be trained during their undergraduate course. Postgraduate courses in this subject should be provided for women already engaged in nursing. The field of the maternity nurses will be so largely among the foreign born that their training should include instruction in the backgrounds of various races of immigrants and in the special technique of dealing with them in maternity work.

DISTRICTING THE SERVICE

Some points made by Miss Frances Perkins, of the Maternity Center Association of New York, in her study of a desirable standard of maternity service, should be incorporated in the proposed plan for organizing maternity care. She suggests that the

ADEQUATE MATERNITY CARE

stations for prenatal and other service to mothers and babies should be regarded as neighborhood centers, and that each "should not be a formidable, official-looking place, but should rather be small, simple, and accessible." In a large community each such center should be organized to care for about 400 cases per year. This would mean one center for approximately each 12,000 or 15,000 population. This corresponds to the general standard for determining the size of a district for general health-center purposes discussed later.

This local center will be primarily the center for the nursing service, although the prenatal clinic will be held there by the obstetrical staff at the necessary intervals. The resident physicians and obstetricians who provide the medical service and supervision must be grouped into larger units, since it would not be economical to have each center for 400 cases a year maintain its independent staff.

Maternity work is of an emergency nature. The approximate date of each confinement can be determined in advance, but not the exact day or hour. It is highly important, therefore, to regularize the calls of both nurses and physicians as much as possible. Regularizing can be managed best when a considerable number of districts are so located as to make it possible to utilize slack time in one, when there happen to be few calls, to fill up the needs in another, where there happen to be many. If too small an area is taken, there will be periods with but few calls, but a large enough staff must be maintained to carry the peak of the load. This defect can be overcome by having many local areas for the nursing and

IMMIGRANT HEALTH AND COMMUNITY

neighborhood service during the prenatal and postpartum periods grouped into larger units.

VISITING HOUSEKEEPERS ESSENTIAL

Visiting houseworkers should be an element in the plan, developed as fully as financial considerations permit. One of the real reasons for the midwife is the help that she gives in the home, and the decrease in this part of the midwife's work is a misfortune to many families. The mother cannot stay long enough in bed after confinement when there is no one to care for her family and children.

Houseworkers maintained on salary could be attached to each center. They should do their work [says Miss Perkins] under the charge of the nurse in charge of the case. They should prepare the patient's food, attend to her minor wants, as directed by the nurse. In addition, they should go out with the nurse and the doctor at the time of delivery, and at once assume responsibilities for the care of the home, including the children. The number of hours per day spent in household work for each patient will vary according to the circumstances and the need of the particular family. These houseworkers should be given certain definite training and instruction before they are sent out.

Miss Perkins estimates that about one houseworker should be provided for every one hundred cases delivered, but this will vary much with the character of the district. The extra cost of these houseworkers may be an obstacle. The amount will have to be worked out. Probably much of this service can be paid for by some families.

ADEQUATE MATERNITY CARE

INTERPRETING

According to the practical experience of the Maternity Center Association, it will be highly necessary to have some one in each center able to speak each language prevalent in the district. Where nurses or physicians of the center speak the languages sufficiently well, paid interpreters need not be engaged. In some centers it will be necessary to engage them or to have a certain number of residents of the district on call for such service, to be paid when called. Usually the need can be met by selecting some one to do clerical or other work at the center who can speak some of the needed languages, supplementing what the nurses or physicians know.

ADVANTAGES OF THE PLAN

The four advantages to their plan are stated by Doctors Rushmore and Paine,¹ as follows:

1. It may be employed in communities in which no medical school exists. These are often the communities in which the need for adequate care is the greatest.

2. It will greatly increase the number of women who get adequate prenatal and obstetrical care.

3. It will tend to improve the standards of obstetrical practice. Hospitals with obstetrical departments will become much more numerous. Physicians who are to be in charge of these departments will be selected because of their greater proficiency and by additional experience will make further progress. House officers will have more experience and better training and thus be better fitted when they enter independent practice.

4. It will greatly increase the supply of obstetrical nurses.

¹ Stephen Rushmore, M.D., and Alonzo K. Paine, M.D., "A Suggestion for Improvement of Obstetrics," *Boston Medical and Surgical Journal*, November 30, 1919, pp. 615-618.

IMMIGRANT HEALTH AND COMMUNITY

This plan would seem to be adaptable to a community of any size where a maternity hospital exists or where maternity beds can be made part of the existing general hospital. It can be applied to small communities, because the overhead costs of providing the expert care, such as the obstetrical and nursing supervisors, can be distributed over a large area. With the development of the automobile there would seem to be no essential difficulty in extending it even to rural areas. The well-trained physician in private practice has nothing to lose by such a system. In fact he would be the gainer by it, because if he wished he could utilize the prenatal nursing service and secure the consultation of the obstetricians of the clinics for his patients without losing his relation with his private case.

Another very important advantage of the plan in communities having many foreign born and many midwives would be that the plan would provide an acceptable substitute for the midwife, at a cost about equivalent to the usual rates for the midwife's services; and that by equipping the "maternity nurses" with proper training in dealing with the foreign born, very great steps could be taken in bringing immigrant mothers to utilize such a service.

Furthermore, an advantage not discussed by Doctors Paine and Rushmore will be very apparent in those communities where there are many midwives and wherein there is a system of licensing, regulating, and supervising the midwives in their practice. This supervision could and should be conducted through the local and central stations of the organized maternity service, to which the midwives would report.

ADEQUATE MATERNITY CARE

The nurses at the station would not themselves be inspecting officials of the Department of Health, which would have the legal authority over the midwives, but the actual contacts between nurses and midwives, as it works out now in New York or Newark, would assist the practice of the better midwives and make the practice of the dirty and untrained ones much more difficult. The officials administering the law of regulation and supervision would be greatly assisted by the knowledge gained through these contacts.

THE CO-OPERATION OF THE LAYMAN

A program of maternity care for the immigrant can be only an academic proposal unless we have always in mind its far-reaching human significance. If we regard the immigrant not as a transient dweller in our midst, but as a part of this country, for good or ill; if we see that Americanization means learning to live together, the approximation of different racial or group standards, the understanding by each of the best in the other, a unifying of communal life into a richer whole than before—then this plan for maternity care can be a powerful instrument in our hands. At the very beginning of life is a strategic time to approach the immigrant, for then a little understanding and sympathy from the American health worker can arouse the maximum return of understanding and sympathy in the immigrant family.

It is well at this point to observe how little the general American public realizes that maternity care

IMMIGRANT HEALTH AND COMMUNITY

is a problem; that in America, even among the native born, the death rate of women in childbirth or from causes directly due to childbirth is shockingly large compared to that of most other civilized countries. Cognately the general public knows little about the midwife or any facility for maternity care other than the private physician.

The native American has not used midwives for a long time. He has heard about them in a vague way, as a rather shady resource of immigrants. He would be astonished to learn that midwives deliver more than a million women in the United States in a year. If he lives in a large city which has a medical school, he would be equally surprised to learn that several hundred, or maybe several thousand, women are delivered annually by medical students.

The people who do use the midwife, the people who do call in the obstetrical teaching service, are the immigrants and the poor; but these have not made known their experience because they rarely have access to the channels of public expression. The specialists have conducted a discussion, chiefly within their own circles. The Federal Children's Bureau has recently been showing in its publications the high rate of maternal mortality in the United States and the grave deficiencies in service to mothers at confinement, discovered in its surveys of rural communities and of towns. These facts are just beginning to filter into lay journals and to receive the attention of public meetings, women's clubs, and other groups wherein plain people come together.

It is well that this is beginning to be so, for whatever policy medical men, health workers, nurses, stu-

ADEQUATE MATERNITY CARE

dents, and surveyors may decide upon, in so large a matter as maternity care for the women of this country a program can be effective only if there is a general appreciation of the facts on the part of the public, a keen sense of the needs that must be met, and an aroused discontent with conditions that must be bettered.

XII

IMMIGRANT DIETS AND AMERICAN FOOD

"SOMETHING to eat" is likely to be the immigrant's first thought after landing, and this fact places food in the first rank of importance in our plans for Americanization. Most of our friends from other countries come to America in the very cheapest way and are unaccustomed to travel. They leave home with many of their cooking utensils in a cloth bag and continue their housekeeping on shipboard, in the steerage, feeding their children and themselves from stores brought from home. Their first impression of America is often got in a poorly housed restaurant, whose proprietor is of their nationality. From him they learn where to get some of their native foods, both raw and cooked.

Usually they establish their homes in neighborhoods or colonies of their own countrypeople. Here they find unfamiliar housing conditions. They are confronted by many new and strange appliances, such as agate and tin cooking utensils instead of copper and iron. There are "so many kinds to learn how to use," such as double boilers, "funny egg beaters that you turn as you do a hand organ," bread pans, and egg poachers. Then, too, there are "stoves with no fires in them and no place for the wood, just

IMMIGRANT DIETS AND AMERICAN FOOD

holes in irons, and if you turn a handle and apply a lighted match fire comes."

In the colony there is no opportunity to learn about American foods, either raw or prepared, nor what American dishes approximate the food values of their various native dishes. Neither do they know the kind and amount of food needed in a day's dietary under the new living conditions. If they have come from countries in which the climate is very different from this, or if their occupation here is more strenuous than at home, or less so, they do not change their menu accordingly. They have always eaten certain kinds of food prepared in certain ways. Why change?

Certain changes, however, are forced upon them by the American market. Some of their old staples are beyond their financial reach altogether or cost more than they seem to the immigrants to be worth. As a result they limit themselves to the few familiar foods easily obtainable, thereby eliminating various essential elements and completely upsetting the balance of the traditional diet, which is not restored by the gradual addition of American products chosen without regard for food values. There is no one to tell them which of their foods to keep and which of this country's to adopt, nor how to prepare them.

There is much that we may learn from these people and equally much for them to learn from us with profit. If we study their ways and customs and acquaint ourselves with their foods, we shall be able to help them to adjust themselves to new conditions with as few changes as possible.

During the influenza epidemic of 1918 it was

IMMIGRANT HEALTH AND COMMUNITY

plainly demonstrated that neither district nurses, settlement workers, nor visiting dietitians knew much about the foods of the foreign-born patients. Gallons of American soups and broths were served to these people, only to be thrown out untouched. This was at a time when diet was an important element in fighting the disease. In our hospitals and dispensaries we usually find only American foods prescribed for diets. Often it has been said, "They should learn to eat American foods if they are to live here." We may not all agree with this, but at least we will agree that when a person is ill and needs a special diet, it is no time to teach him to eat new foods. It is like hitting a fellow when he is down. Our milk soups are nutritious, but so are theirs; why not learn what they are and prescribe them? The same is true of other foods.

It is much easier for the dietitian to learn the foods of the foreign born than for these people to adjust their finances to a new dietary. Often their income is insufficient to buy the foods which they know they like. Can we wonder that they hesitate to invest in food about which they are uncertain?

A Bohemian family of father, mother, and six children, who were patients at a dispensary, were living (or staying) here on an income of twelve to sixteen dollars a week. It was necessary to get milk and cereals into the diet of the children, but who, without a knowledge of Bohemian foods, dare disturb that very limited amount which could be spent for food?

Mrs. Angelo's husband is a printer, who earns seventeen dollars a week. They have seven children,

IMMIGRANT DIETS AND AMERICAN FOOD

the oldest a boy of eleven. Barbara, five years old, was very bowlegged and had to have her legs broken to straighten them. Three younger children were sent to a dispensary food clinic for diet to prevent their being bowlegged. It was necessary to have not less than two and one half quarts of milk added to their food each day. The income was too small to allow this, so the man got night work to pay for the milk. This shows that they were willing to go at least halfway in changing diet habits.

The derangement of the hereditary diet often presses hard on the children. Although the immigrant mother is accustomed to breast feeding her babies, often nourishing them thus long after the usual period, early in life the child is given other food, too often from the family table. The beneficial effects of breast feeding, therefore, in reducing infant mortality, are often counteracted after the first few months of life by unwise additions to the child's diet. The unwisdom of these is often explained by the immigrant's dietary backgrounds. Much instruction for American health workers lies in this true story, told by the nurse in a certain clinic. A sick baby had been brought in for treatment. Bad diet was evidently the trouble.

"What do you give the baby?" asked the nurse through an interpreter.

"What we have ourselves," was the reply.

"But why should you do that to a little baby?" chided the nurse.

"I always did that in our own country with my other children before we came here."

"But what did you give your children in the old country that you had yourselves?"

IMMIGRANT HEALTH AND COMMUNITY

IN EUROPE THE MILK SUPPLY WAS IN THE FRONT YARD

"Soup and buttermilk," answered the mother, smiling, apparently at the pleasant recollection of those days.

"What do you give your child now that you have yourselves?"

"Beer and coffee."

IMMIGRANT DIETS AND AMERICAN FOOD



IN AMERICA MILK FROM A DISTANCE MAKES NEW REQUIREMENTS

The changed relation of the immigrant family to the milk supply is of great importance for the maternity and child-welfare worker. A nurse finds, for instance, an Italian mother giving her child no milk;

IMMIGRANT HEALTH AND COMMUNITY

or a baby sick from impure milk; or again, youngsters of five or seven years of age getting along with no milk, or only a tiny bit of it in their diet.

In her native land this Italian woman probably went out of doors, chased the goat, milked it, and gave her child to drink. The milk was comparatively clean and too fresh to be contaminated by the growth of bacteria. Then this woman comes to America; she has to buy milk, and it seems to cost a great deal. It has been a drink to her, and its food value is not appreciated. It seems astonishing to have to pay out a large sum of money for merely something to drink, something, furthermore, which the adults of the family—particularly the man—are likely to care very little about. In other countries, like Russia and Poland, they “live on the cow.” Milk usually costs nothing in cash, only labor.

From immigrants with these backgrounds it is unreasonable to expect a sufficient and wise use of milk, which must be purchased and cared for under city, or even town conditions, in the United States, unless there is built up a wholly new attitude of mind and of family habits in regard to it.

There are certain diseases prevalent among the foreign born which are connected with their change of diet. If this is corrected it may overcome the disease. In adapting diets, the conditions and dietary habits of the people in their own country, as well as their food problems here, must be considered. We shall make special reference to some diseases in which diet is a factor and which are most frequently noted by physicians, nurses, and social workers. Fortunately it is possible to make foreign recipes from our

IMMIGRANT DIETS AND AMERICAN FOOD

American raw materials, and many of them resemble our dishes so closely that only slight changes in our recipes are necessary to produce a welcome diet for these people.

A study of this kind should be extended to more race groups than the four which we have taken up as examples. It would be useful to enter into more details in many respects, for success in dietary work is largely a matter of applying certain general principles to special problems. However, a study of the diets of the Italians, Jews, Poles, and certain Near East races may serve as an example of what can be done in adapting immigrant tastes to American foods. Recipes for each nationality are to be found in the Appendix.

REPLACING ITALIAN FOOD

The Italians who come to America are the peasants or country land workers. They are heavily taxed at home; ready money is scarce, and saving is a slow process. The needs of the family are supplied directly or by exchange with neighboring farmers. Italy has a climate much like that of California, which gives the people a long farming season. But in the hottest part of the summer in southern Italy very little work is done during the middle of the day.

Wheat, corn, and other cereals, vegetables, fruit, chickens, pigs, and goats' milk, constitute the food products of the farms. A greater variety is found on some farms than on others, depending on the ambition and energy of the farmer. The Italians make their own cheese from goats' milk; they lay in a store of dried peppers and strings of garlic for

IMMIGRANT HEALTH AND COMMUNITY

the winter, and they make enough tomato paste to last during the season. Here and there one finds olives raised for family use. These are pickled, both ripe and green, and used not only as a relish, but cooked with macaroni or, in northern Italy, with corn meal.

The country people of northern and central Italy have a well-balanced diet, with protein from milk, cheese, eggs, and meat; carbohydrates from bread, and various forms of macaroni; mineral matter from fruits and vegetables; fat from olive oil; and vitamins from milk, vegetables, and egg yolks. Southern Italians obtain a more varied diet than the other two groups, by the addition of innumerable kinds of fish. The Italians in the cities use more pastry and cake than the country people, and have altogether a more expensive and varied diet.

In the United States the Italians find plenty of the foodstuffs to which they are accustomed, but everything is very expensive, notwithstanding the higher wage scale. More meat can be had than in Italy, and they enjoy that. The high price of eggs is almost completely prohibitive. They like vegetables, but to use enough of them to get the amount of satisfaction and bulk to which they are accustomed, costs too much. Milk is considered a drink, and is purchased only after the solid food is bought.

These conditions result in one of two compromises: either they leave out both milk and meat and live largely on starches—bread, macaroni, and potatoes—and vegetables; or meat is used at the sacrifice of both vegetables and milk. The health of the family naturally suffers through this change of diet.

IMMIGRANT DIETS AND AMERICAN FOOD

The Italian woman, when she cooks a meal, spends much time and care, and the results are very appetizing. This fact shows what an apt pupil she would be if taught early on her arrival how to market, what familiar foodstuffs can be secured, what substitutes can be used, and what a day's dietary, breakfast, dinner, and supper, should contain, and why.

In furnishing this instruction, native dishes and raw-food materials should be included wherever possible. If olive oil is a luxury, other vegetable oils, of which we have several, may be introduced. Soups may be given the Italian flavor of tomato or garlic or both. To them may be added macaroni in one of its various forms, or rice, and this will furnish thickening in place of eggs. Milk soups will be acceptable only when highly flavored or after the family have learned to like white sauces. Vegetables the Italians have always liked, and when their value is explained they are often willing to substitute them for meat.

The Italian children are put on the adults' diet as soon as they are out of swaddling clothes. The larger the abdomen the stronger and healthier the mother considers the child. A diet of milk, strained cereal, and fruit juices is unknown to an Italian mother. The children learn to take tea or black coffee and bread without butter, for breakfast. Usually this means a meal of 200 to 250 calories, composed of carbohydrates, instead of one of 500 calories, combining protein, carbohydrates, mineral matter, and fats. At noon the meal often consists again, as with the adults, of bread with a piece of bologna and more tea or coffee. At supper time comes the big meal of the day. Too large an amount of macaroni

IMMIGRANT HEALTH AND COMMUNITY

or rice, and lard, is usually included in the diet, with few vegetables and little fruit, and often the children suffer from constipation because of this excess of starch.

Very often bringing a child back to normal health and development is only a matter of readjusting diet. With a slight knowledge of their predilections this can be done. They do not need to be encouraged to eat macaroni, vermicelli, or spaghetti. They are quite ready to eat oatmeal or rolled oats if these are cooked in milk and with raisins. Undernourished children should be given soups¹ and milk, plain or in custards.² Other recipes for children may be found in the Appendix.³

A constipation diet includes vegetables, cooked in any of their many different appetizing ways, and fresh fruit or fruit juices. When constipation is found among Italians it is usually because they have been financially unable to secure vegetables, fruit, and olive oil, and have lived exclusively on macaroni, rice, and lentils.

If any protein is to be allowed to an Italian with nephritis, cheese should be selected. He does not miss the other forms of protein so much. He uses very little meat at any time; eggs are used as thickening and would not be missed if another thickening were used, but cheese furnishes flavor for many dishes.

Tuberculosis patients may be given milk in the forms prescribed for undernourished children, and eggs in soups. The Italian people are not in the habit

¹ See Appendix, recipes 1, 2, 3, 4.

² *Ibid.*, recipes 5, 6.

³ *Ibid.*, recipes 7, 8, 9, 10, 11.

IMMIGRANT DIETS AND AMERICAN FOOD

of using soft eggs, although they have many recipes for using hard-boiled eggs. Patients can be taught to eat them poached or dropped, and served with a little grated cheese. Sugar may be prescribed in fruit compotes or in stewed fruits, made of either fresh or dried fruits. Raisins and almond paste are other forms of sweets.

Diabetic patients find it very hard to go without *pasta* or macaroni. Among the poorer people it has been the staple at every meal. Vegetables, used by them in many combinations, are prescribed for this disease. Tomatoes may be scooped out and have an egg dropped in each, then placed in a small dish and baked until the eggs are set. Mushrooms are often chopped and baked in tomatoes. Beans of all kinds must be forbidden. Often the use of mushrooms may be encouraged in their place. Endive is enjoyed, as are dandelions and spinach.

If Italians can secure the diet they prefer, it is usually well balanced, and the women are naturally good cooks. A person who knows the native dietaries can help them to adjust themselves successfully to the conditions in this country.

JEWISH RELIGIOUS RESTRICTIONS

The wanderings of the Children of Israel since Bible times have made them an international race. They have known all countries, and adapted themselves to different climates and products. Because of these conditions they have a more varied dietary than any other people. They know the Russian, Polish, German, Spanish, and Italian foods, and have adapted them to their dietary laws.

IMMIGRANT HEALTH AND COMMUNITY

It is essential that the Jewish dietary laws be understood by all who attempt medical or social work among orthodox Jews. They are embedded deep in their religion and custom. Among no people is infringement of them so unthinkable and of such grave consequence. A useful paper by Mrs. Mary L. Schapiro, giving the essential laws, should be consulted in this connection.¹ Only a brief summary is included here.

The prohibitions on Jewish diet are of three kinds: on the kind of food; on the preparation of food; and on the time different foods may be used. The only meat that can be used is that from clean animals, "quadrupeds that chew the cud and also divide the hoof." They must have been healthy and killed in a certain way. Only fish having "fins and scales," and birds which are "not scavengers or birds of prey," can be eaten. Suet is forbidden, but not fat.

There are many restrictions on the preparation of different foods. The most important is the absolute prohibition against cooking meat and milk together or eating such mixtures. This rule is rigidly adhered to, and in its present application necessitates the use of a complete double equipment of dishes and utensils. Since this rule is regarded as one of the most important, one can understand why butter or milk sauces are refused at meals with meat. It occasions the home-economics teacher a great deal of trouble in planning menus. Meat and fish are another combination that must not be cooked together.

¹ Mary L. Schapiro, "Jewish Dietary Problems," *The Journal of Home Economics*, vol. xi, no. 2, February, 1919. An extract is included in the Appendix.

IMMIGRANT DIETS AND AMERICAN FOOD

In prescribing diets for the Jewish people it is helpful to remember that all foods may be classified under three heads: (1) Meat; (2) milk and its products; (3) neutrals. Meat and milk are never mixed. Neutrals may be used with meat or with milk products, but never with both in the same meals.

In addition to the daily food restrictions there are periodic holidays that must be strictly observed in the diet. No food can be cooked on the Sabbath. "During Passover week no leavened bread or its product, or anything which may have touched leavened bread, may be used." This means there is a thorough housecleaning in preparation for this week and a sterilization of all utensils. "A complete new set of dishes is used during the week." In addition there are several fast days and semifast days with special restrictions.

Some indication of the cosmopolitan diet of the Jewish people may be had from the following quotation from Mrs. Schapiro's study:

From Spain and Portugal comes the fondness of the modern Jew for olives and the use of oil as a frying medium. The sour and sweet stewing of meats and vegetables comes from Germany. The love of pickles, cucumbers, and herrings comes from Holland, as also does the fondness for butter cakes and *bolas* (grain rolls); from Poland the Jewish immigrant has brought the knowledge of the use of *lokschen* or *fremsel* soup (cooked with goose drippings), also stuffed and stewed fish of various kinds. From Russia comes *kasha*, made of barley or grits or cereal of some sort, which is eaten instead of vegetable with meat gravy. *Blintzes* are turnovers made of a poured batter and filled with preserves or cheese, and used as a dessert. *Sholent*, sometimes called *kugel*, are puddings of many kinds, such as *magan*, *lockschen*, *farfil*. *Zimes*, or compotes of plums,

IMMIGRANT HEALTH AND COMMUNITY

prunes, carrots, and sweet potatoes, turnips and prunes, parsnips and prunes, and prunes and onions are all puddings, and come from Russia. *Zimes* of apples, pears, figs, and prunes are southern Rumanian, Galician, and Lithuanian as well.

The Jews have derived certain dietary habits from their religious laws and their long international experience. The dietary restrictions on the use of butter and meat at the same time limit the use of vegetables, so that the Jewish people are not so fond of them as they ought to be for their own physical well-being. The Jewish housewives utilize a small amount of fresh meat in dozens of ways. They have long known how to use honey, molasses, and syrup, in place of sugar. Sugar has been a luxury in many of the countries from which they come. They have also been fond of rye, barley, oats, and buckwheat. These cereals are used in both puddings and soups. They have little knowledge of stewed fruits, but do have many kinds of rich, preserved fruits. All these highly seasoned foods they have in abundance, and it is with difficulty that a taste for the simpler foods is cultivated. Probably no other people have so many kinds of "sours" as the Jews.

In the Jewish sections of our large cities there are storekeepers whose only goods are pickles. They have cabbages pickled whole, shredded, or chopped and rolled in leaves, peppers, string beans, cucumbers, sour, half sour, and salted, beets, and many kinds of meat and fish. This excessive use of pickled foods destroys their taste for milder flavors, causes irritation, and renders assimilation more difficult.

When the Jew arrives in this country some of the

IMMIGRANT DIETS AND AMERICAN FOOD

limitations of his diet, if unchanged by instruction, are evident. Many of them pay little attention to their diet during the week, until their Sabbath. Then on Friday night, on Saturday, and on Sunday—which to most of them is a holiday—they have a feast time. On Friday all the cooking is done for the next two days. Chickens are cooked, soup made, and *kuchen* (cakes) and *mehlspeise* (flour mixtures) prepared. As a result of these weekly feasts many of the Jews eat too much, or else have not a well-balanced ration. By nature the Jews are an emotional people. A slight physical discomfort often sends them to a doctor when the readjustment of their diet would produce a cure.

The Jewish children suffer from too many pickles, too few vegetables, and too little milk. Enuresis is quite common among these children, induced by the highly spiced foods in their diet and the pickles eaten at and between meals.

For undernourished children among the Jews, it is necessary not only to urge the use of milk, but to plan when it may be taken, as it cannot be taken at the same meal with meat. Therefore midmorning and midafternoon meals of milk must be introduced. This is impossible for the children who eat in school, unless there is a school lunch.

Vegetables are usually needed in greater abundance. These may be eaten in *borsch*, a favorite soup much like our vegetable soup, but this does not give them in very large portions. Therefore, a menu should be planned to show how they may be combined with other foods. If served with a white sauce or butter, vegetables cannot be eaten with meat, but

IMMIGRANT HEALTH AND COMMUNITY

they can be eaten at the noon meal or lunch with bread. Creamed vegetable soups also may be given in this way, but never at the same meal with meat.

In the treatment of constipation, which is very frequent, six glasses of water a day are prescribed "to *kasher* the intestines," cereal pudding, or *krupnick*, is given, also rye bread or "Jewish black bread," and *borsch* once a day. The recipes for *krupnick* and *borsch* are to be found in the Appendix.¹

Many Jews have diabetes. When prescribing for them, one has not only to give a new dietary, but also to teach new ways of cooking the foods allowed. For example, they are accustomed to cooking vegetables in small quantities, with beef; but for the diabetic this is excluded, and new recipes must be introduced. All five and ten-per-cent carbohydrate vegetables may be served with drawn butter, white sauce, or a hollandaise sauce, or with salt and a small portion of lemon juice or vinegar. Green peppers stuffed with vegetables make a pleasant variety. Liver, which is frequently used, must not be allowed in the diet. The patient must be warned not to eat during Passover *mazzah*, or unleavened bread made of flour, salt, eggs, and water, in the form of large crackers. Eggs baked in spinach, or scrambled with mushrooms, may be eaten. The Jewish people are fond of the flavor of almond omelet, instructions for making which are in the Appendix.²

In cases of nephritis, the use of all pickled foods and "sour salt" should be discouraged. Almost all their soups are low in protein. Many of their meat

¹ See Appendix, recipes 12, 13.

² *Ibid.*, recipe 14.

IMMIGRANT DIETS AND AMERICAN FOOD

dishes have little meat in them, as, for example, *bitki*, or Hamburg steak.¹ Both *kascha* and *schavel* are dishes that can be recommended and enjoyed.²

The diet for a Jewish tubercular patient would have less carbohydrate and more protein than is usually found in the Jewish daily dietary. Milk and eggs may be given between meals in both the mid-morning and the midafternoon, and before bedtime. This would not interfere with their eating meat at lunch and dinner. The staple *borsch* may be used, made without meat, and with the addition of sour cream. Sour cream is a favorite dressing for berries or fruit and may be used freely by these patients.

For these diets the American way of preparing certain foods should be taught. The Jews like to scramble their eggs with vegetables³ or bake them in a nest of vegetables. The process of poaching or "dropping" eggs is unknown. A "dropped" egg was prescribed for a patient at a certain food clinic. When it was explained that an egg was broken and its contents dropped into hot water, he shook his head and said, "Oh no! I lose my egg; he get all mixed with the water." When he was taken to the stove and saw an egg poached, he stood in wonder and admiration. He said, "I go home tell my wife; she never knowed that." Since then many mothers and even children have been shown in this same clinic how to poach eggs.

All cereals must be tested as follows: "Place them on a hot plate. If no worms or other

¹ See Appendix, recipe 15.

² *Ibid.*, recipes 16, 17.

³ *Ibid.*, recipe 18.

IMMIGRANT HEALTH AND COMMUNITY

insects appear they are fit to be eaten; if not fit they must be thrown away." The cereals used by the Jewish people are barley, oats, buckwheat, and rice. These are baked in puddings and eaten with meat. Children soon learn to eat cereals boiled with milk, and will learn more easily if raisins are added. The making of all kinds of milk dishes, from a plain boiled or baked custard to a Bavarian cream, will have to be taught. The Jewish housewife has had to adapt herself a number of times to new foods and their preparation, each time remembering her dietary laws and arranging the recipes to conform to them. This fact makes her an apt pupil.

PEOPLE OF THE NEAR EAST

The Armenians, Syrians, Turks, and Greeks are interesting peoples. With their love for friend and neighbor, creators of works of art, dwellers in the out of doors, they have much to give to any country. In the matter of preparing food we can well profit by knowledge of their ways.¹

The majority of those who come to America lived in their native lands in the open country among the foothills or on the high table-lands. A minority dwelt in the smaller cities.

Early in March, in the home country, the whole family changes its mode of living from indoors to out in the open. This is the season for plowing and planting, meals are prepared and eaten out of doors,

¹ Comparison at some points may be made with the Mexicans, whose dietary problems deserve special study. See "Dietary Studies of Mexican Families in New Mexico," 1897 (*Bulletin 40 of the United States Office of Experiment Stations*).

IMMIGRANT DIETS AND AMERICAN FOOD

and the evenings are spent under the great canopy of blue and gold, with the family and relatives telling the news of the day and exchanging stories. Some of these stories have been related many times before, but their familiarity only makes them more interesting.

These people practically live out of doors, working in the fields or harvesting their supplies, until late in November. Then they take up different lines of craft work. Many pieces of copper and brass are tooled and etched during the winter months. Some of their wonderfully beautiful rugs are woven then. A pleasant pastime for the older women is dyeing the yarn with the gathered vegetables, mixing a little of this color and a little of that color to get just the shade to harmonize with the design in the mind of the weaver. It is difficult to distinguish between work and recreation among these people.

During the farming season they raise sheep for food and clothing; goats and cows for milk, butter, and cheese; chickens, ducks, and geese for eggs; and grains, vegetables, fruits, and berries in abundance. Their wheat is threshed in the fall, then taken to the one neighborhood caldron, where it is boiled "until all germs are killed," and spread out on great sheets of cloth to dry in the sun. After it has dried it is ground between two great stones to different degrees of fineness. This grain is used in many different ways; it is even burned as incense.

Olives are pickled, both ripe and green, and some are salted. Wines and raisins are made from grapes and the leaves of the grapevines are salted, to be used later for wrapping *dolmas*. Figs, dates, and

IMMIGRANT HEALTH AND COMMUNITY

other fruits are preserved in sugar. Potatoes, squashes, onions, garlic, and other vegetables are put in pits in the ground. At least three lambs are salted. In the Orient, lamb is the principal meat used.

Rice has a large share in the daily menu. The use of nuts with rice and meat adds attractiveness to the diet. Pine-cone seeds, or *fustuck*, hazelnuts, or *fanducks*, chestnuts, or *kestanch*, pistachio nuts, and coriander seeds are some of the seeds referred to in Oriental recipes. Cardamon seeds are frequently added to coffee. Chick peas, or *nohond*, a product of Greece and Turkey, and *fava*, *pakla*, or horse beans, two of the leguminous plants used, have a high food value. There are various wheat preparations in which the grain appears in different forms.

In Eastern cookery not a single dish is dependent on the extravagant use of expensive ingredients; every dish is dependent, and very much so, on the flavor of each article used in its making. Oriental food is not highly spiced or flavored, but it is a very fat diet. Butter is not eaten on bread, the fat in the food preparations being sufficient.

The breakfast of these Easterners consists of black coffee and bread for the adults and goats' milk and bread for the children. In some families cracked wheat boiled with milk is used as a cereal.

The noon meal may be *matzaun*, or curdled milk, with a "dressing" of *pilaf*. *Matzaun* or *yoghourt*¹ is the famous beverage or soup of the Orient. It is served either hot or cold or sweetened with sugar. It is as valuable in their diet as buttermilk in ours.

¹ See Appendix, recipe 19.

IMMIGRANT DIETS AND AMERICAN FOOD

For the dinner or evening meal, *shish kibab*—lamb cut in walnut-sized pieces and roasted on skewers—is a favorite meat dish. All vegetables are first fried in a small amount of olive oil or other fat, then boiled in meat stock. Sometimes tomato is added to give more flavor. Okra is never slimy, and vegetables lose their green taste when first cooked in oil or other fat.

When these people settle in America the men are seldom laborers; almost all choose commercial occupations. Many of our finest fruit stores are owned by Greeks, Armenians, or Syrians. They usually start with a pushcart of fruit; frequently bananas, and gradually work up a trade, buy a horse and wagon, then establish a small store. Others are waiters in restaurants or have shoeblacking stands. Some sell antique rugs, or clean and repair them. Because of their indoor occupations, their incomes are more regular than the incomes of those who are laborers or do other seasonal work.

There are comparatively few Eastern women over here. Often an Easterner and his wife run a restaurant and board a number of men. Sometimes a bulletin board is hung in these places upon which letters received from home are posted for others besides the recipient to read. Eating at these restaurants is a social occasion; the food is well cooked, although the service lacks some of the conventionalities of this country.

In this country these Easterners continue their dietary customs to a large extent. It was interesting to find, during the war, that they were still able to secure wheat in its different degrees of coarseness.

IMMIGRANT HEALTH AND COMMUNITY

Fruit, however, is not so plentiful, and milk becomes a luxury. A Syrian woman who had tubercular glands was advised to use one quart of milk a day. She showed no improvement, after being treated for some time, and it was discovered that she had not had the milk. When asked why she did not take it, she said: "The milk come in a bottle; in my country I get it from the goat. The doctor ordered milk, and I do not know what else is in the bottle; there must be something besides milk, to make it cost so much." All was explained, and milk ordered for the patient. She began to improve, and then she was convinced that although we have an expensive way of obtaining milk it has the same virtue as at home.

Among the Syrians, Armenians, Greeks, and Turks we usually find the children well nourished, with plenty of growth material and mineral matter in their diets. They do not have milk and fruit in as large quantities as they should, because of the expense.

The undernourished children need more milk added to their diet. Wheat is used extensively, either whole or cracked; it is cooked in water until nearly done, then milk is added for the last few minutes' cooking. Even the candy or sweetmeats, called *medley*, is made with wheat.¹ The green-leaved vegetables are not used in cream soups, but are cooked in stock. This must be remembered in diets for children.

A Greek boy, a patient at a dispensary, was referred to a food clinic for a constipation diet. When questioned about the delicious orange compotes the

¹ See Appendix, recipes 20, 21.

IMMIGRANT DIETS AND AMERICAN FOOD

Greeks usually have two or three times a day on their tables at home, he said: "Oh yes! My mother makes it, but she keeps it for company. When she is out I crawl in the window and eat some on my bread. Oranges cost a lot for boys, my mother says." Dried as well as fresh fruits may be prescribed, but they should be as compotes, not "stewed."¹ The national dish of the Turks is *pilaf*; of the Armenians, *herissa*. Both of these are good foods for the children.²

When vegetables are prescribed, it is well to remember that the Oriental cooks them with olive oil. They are known as *basidis*, and are used extensively cooked with meat or in olive oil, or both. One of the best dishes for a patient with constipation is cabbage with meat.³ Another dish equally valuable is *tureli ghuvedge*, or mixed vegetables with meat.⁴

Nephritis seems to be almost unknown among these people. A patient may have any of their cereal dishes made of wheat or rice and any of their green vegetables cooked in olive oil. Suggestive combinations for them are given in the Appendix.⁵

Because of the large amount of rice and wheat used in Oriental dishes, it is difficult to plan a diet for a diabetic patient. In prescribing low-carbohydrate vegetables cooked in olive oil and lamb and chicken cooked on skewers, one can be sure no rice or wheat is used.

The tuberculosis patient should have black coffee replaced by milk in his diet. Several milk dishes are

¹ See Appendix, recipe 22.

² *Ibid.*, recipe 25.

³ *Ibid.*, recipes 27-30.

⁴ *Ibid.*, recipes 23, 24.

⁵ *Ibid.*, recipe 26.

IMMIGRANT HEALTH AND COMMUNITY

given in the Appendix. *Tzouvatzegh*, the Armenian egg milk toast, is very good.¹ *Matzaun* is always popular and may be combined with eggs.² A favorite egg dish is made with orange and is called *sudeli youmourta*.³ Buttered bread is often served with a pitcher of hot milk, and eaten as we eat bread and milk.

The people of the Near East seem to have a greater knowledge of food combinations than any other people. It is generally supposed that their cookery is spicy, but it can be seen from their recipes that the cooking is rich, not in condiments, but because of the number of ingredients.

POLES AND OTHER SLAVIC PEOPLE

The Poles come from a northern climate, where the summers are not so long as the winters. Very few people from the cities of Poland come to America. Those we find here are the peasant class. On their farms they raised the grains and vegetables that develop during a short season—beans, carrots, turnips, parsnips, cabbage, lettuce, and other summer vegetables. Tomatoes are not raised nor are they known outside of Warsaw. They raise stock from which they get milk and meat.

Meat has a prominent place in the Polish diet—beef, veal, and pork being the kinds in common use. These are roasted plain or boiled in various combinations. Pork is perhaps the favorite, and they have many ways of making it into sausage and of smoking it. When smoked it is often covered with

¹ See Appendix, recipe 31.

² *Ibid.*, recipe 32.

³ *Ibid.*, recipe 33.

IMMIGRANT DIETS AND AMERICAN FOOD

mace to add flavor. This is true not only among the Poles, but among other Slavic people. Pork is frequently used with beef and made into puddings or loaves. In the winter the only fresh meat used is game, and it is customary to roast this over an open fire. Eggs instead of meat form the dinner dish on Wednesday and Friday. Sometimes chickens or ducks are used.

Fish is used fresh in summer and pickled in winter. It is rarely preserved by salting. Fish is boiled or baked, but for special occasions the best cooks prefer to make it into cutlets. These are made of cooked fish blended with a sauce or gravy, shaped into cutlets, and fried or baked with a sauce or gravy.

Potatoes are served at almost every meal. The preferred grain among all the Slavic people is barley. The Poles use corn meal and oats also.

When the man of the family gets his first job in this country, it is as a laborer, sometimes building our railroads, bridges, or subways. He generally carries his noon luncheon to work and it consists of bread broken from a loaf, either round or oblong, according to which shape fitted the oven. With this he may have some *bizos*, if he is Polish. *Bizos* is made of two kinds of sausage, red and white, sauerkraut, tender beef, pork, and barley, all boiled together into a thick pudding. It is sliced, and eaten cold or warm. In his own country *bizos* was one of the luncheon meats taken on hunting trips, and as the laborer sits on the curb, or out along the railroad he is helping to build, his enjoyment of the lunch is accompanied by memories of those hunting expeditions and the friends who were with him.

IMMIGRANT HEALTH AND COMMUNITY

The family diet slowly changes from flour gruel and potatoes, with coffee, for breakfast, to more American dishes. They continue the custom of having eggs for dinner on Wednesday and Friday as long as they are able to afford it. In winter, because of the high price of eggs or because the man is out of work, they must find a substitute or, what is more frequent, go without. Flaxseed oil is their favorite fat. That is hard to find here, and this necessitates learning to use some of the vegetable oils which we have.

{ The Polish children, and those of the other Slavic people, come from sturdy stock. Upon arrival in this country they have round, well-shaped heads, rosy cheeks, and strong bodies. With their kerchiefs over their heads they make fascinating pictures of health. They have had an abundance of milk and fresh air in their own countries.

Here they live at first in crowded districts. Milk is counted as a drink, not something to eat; therefore, because the family income is small, it is left out of the diet almost entirely. If these children are fortunate enough to belong to Polish families that have saved and bought land in the country, for tobacco or onion farms, they have goats' milk, vegetables, and fruit. Otherwise they eat what the grown-ups have, and they pay the price. Sometimes they are constipated, with accompanying ill feelings; sometimes they are under weight.

In cases of undernourishment among the children it is necessary with the Slavs, as with all other foreign-born people, to help plan for milk in the food budgets. Among their soups, children may have *rosolzazan-*

IMMIGRANT DIETS AND AMERICAN FOOD

kamt, a consommé with eggs dropped in it. Eggs are beaten as for scrambled eggs, and dropped into the hot soup by small spoonfuls just before serving. They may also have chicken soup, or *krupnik palski*, which is prepared with barley. Cereals are eaten not only for breakfast, cooked in milk, but in soups and baked and served with meat. As vegetables are seldom cooked and served without meat, it is necessary not only to prescribe them, but also to show how to make purées and to cook plain vegetables. *Kieselle* is one of the desserts children like; it is made of blackberries, raspberries, or black concord grapes.¹

A constipation diet is a very easy one to find for these people, as they are accustomed to eating many vegetables. *Szynka pieczona zkasza*, ham roasted with cabbage, or *rozbiantere dusgony*, roast fowl with vegetables, illustrates how inseparable are their meats from their vegetables. *Dusgony*, or vegetables, they welcome on a diet list. Coarse-grained cereals they use, as *kasza*, boiled in milk or baked in water, with milk and fat added during the baking to give moisture.

The diabetic patient finds consolation in the number of fish dishes known to the Poles and Russians. *Ryba wgalarecie*, or fish in jelly, is much enjoyed. The jelly is made with lemon, and the first layer often has chopped cabbage or celery in it. When this is set the fish, already boiled, is placed upright in it, and covered with more cooled jelly. Another favorite dish is made of the gelatin from the feet of the pig, with meat from the hocks. *Ciely*, or veal roasted or made into cutlets, may be used; also pork,

¹ See Appendix, recipe 34.

IMMIGRANT HEALTH AND COMMUNITY

or *wieprzony*, prepared in a number of ways. *Sledy pocztomy* or *maatjis* herring is often used for supper.

For nephritis patients, it is hard to separate protein from vegetables. Their vegetable soups, made thick with vegetables, are useful in such a diet. *Zupa jarzynowa* is vegetable soup made with a foundation of chicken stock and any or all kinds of seasonable vegetables. Soup, or *rosal*, with *makoronom*, or noodles, cannot be included, but *borszoz zabillang* can be given. This is a soup made by boiling both the tops and the roots of beets and adding fat and sour cream.

Tuberculosis patients will benefit from the *smietanie*, or cream sauces, which are used for vegetables, meats, and game. *Ovsyanka* is a very good oatmeal soup.¹ Flaxseed oil with a small amount of lemon juice is a favorite salad dressing.

APPLICATION TO HEALTH WORK

From our studies of dietary backgrounds it is apparent that a family coming to this country from a wholly different environment is under an enormous handicap in attaining a satisfactory diet, particularly when the income is small. Moreover, doctors, nurses, social workers, and even dietitians generally lack knowledge of the native diets and food habits of the foreign born.

Against these limitations must be set the fact that a large number of the foods of foreign-born peoples are well adapted to their physical needs, and that most of these can be obtained in this country. Furthermore, dietary errors are largely due to dis-

¹ See Appendix, recipe 35.

IMMIGRANT DIETS AND AMERICAN FOOD

turbance of balance in the diet because of change of environment or new scales of prices. The problem before the dietitian is not so much to introduce a complete "American" dietary, as it is to restore the former dietary balance by supplying lost elements.

KNOWLEDGE OF IMMIGRANT'S FOOD ESSENTIAL

Knowledge of the foods of the foreign born and of their native dietaries is the foundation of all success in this endeavor; it is a necessity in dealing with many specific problems of health or of disease, and it is invaluable as a means of mutual understanding and sympathy between the American born and the immigrant. "The way to a man's heart is through his stomach." The soul of a family may be reached through the daily chores of the household.

The following story illustrates how a sympathetically prescribed diet, recognizing the value of familiar national foods, can aid in winning the friendship of individuals. A Russian woman was asked to interpret for a Ukrainian at a food clinic. She was not much interested at first, but when some of her national foods were mentioned she looked up, and said to the dietitian, "I only been here in this country three years, but you my sister." She then urged the patient to use the food prescribed, and was much more diligent thereafter in her own regimen.

NEED FOR PRINTED MATERIAL

Certain particular needs become evident as the result of this incomplete and tentative survey. There is a demand for printed material for professional workers,

IMMIGRANT HEALTH AND COMMUNITY

such as visiting nurses, dietitians, domestic-science teachers, and social workers. This material should be published in several forms, as:

(a) A textbook for colleges and hospitals, in which young women are trained as domestic-science teachers, dietitians, or nurses, including a list of foods and the recipes of foreign diets corresponding to well-balanced American diets.

(b) A book somewhat less formal in character, for dietitians, visiting nurses, and medical-social workers, covering the diets of the different nationalities and races in relation to health, with particular instructions in the preparation of food, as well as descriptive matter and general principles.

(c) Single reprints in leaflet form of this material for each nationality or race, each reprint containing some statement of general principles, a brief account of the dietary background of the race group, and practical recipes. This might not only be available for the worker, but could be given with discretion to the foreign born.

Published material which would enlighten Americans regarding the practical utility and enjoyability of many foreign foods could be widely used. A study of "Foreign Foods Which Would Improve the American Dietary" would be an Americanizing agent of practical value for the use of home-economic sections of women's clubs and similar organizations. American diet would be improved and enriched, and many Americans would be given a sympathetic appreciation and understanding of our foreign-born population through the practical medium of the kitchen and dinner table.

IMMIGRANT DIETS AND AMERICAN FOOD

The great practical interest which everybody has in food should be used in teaching English. There seems to be need for the preparation and publication of an American home-making primer, telling briefly and simply what to buy, how to use American stoves and American utensils, and introducing the best American foods to the reader. Such a primer might be especially good for the foreign born who have just learned or are just learning English. It might also be printed in a foreign language or be bilingual.

INTERNATIONAL MENUS FOR INSTITUTIONS

An international menu should be used in institutions of all kinds receiving any number of foreign born. An international menu is one which is not confined to American dishes, but which contains each day at least one dish especially adapted to one of the nationalities or races represented among the patients. This would demonstrate to the patients that the dietitian has considered them and the psychological effect would help them physically. Thus in a menu for an institution with many different race groups, a characteristic Italian dish might be included one day, a Polish dish another, and the next day the Jewish or Russian patients might be remembered. Such a menu need not make the diet less acceptable to the native-born Americans. It would give greater variety and would help the dietitians in their endless search for something new. So all would be better satisfied both physically and mentally.

The work of making up such an international menu is a matter of practical and not difficult detail. Die-

IMMIGRANT HEALTH AND COMMUNITY

titians or others responsible for the menus in hospitals, sanatoriums, convalescent homes, restaurants in industrial plants, should develop something of this sort, wherever the racial constitution of their people requires it.

The diet lists used by medical institutions, such as hospitals and dispensaries, should be adapted to the people as well as to the diseases which are treated. The habitual foods of the nationality or race dealt with must be in the mind of the person who prepares the diet list, if it is to be of real service. This means that the dietitians, visiting nurses, or social workers who handle the dietary problems of the patients should have some knowledge of foreign as well as of characteristic American diet.

The average visiting nurse or medical social-service worker is not expert in dietetics and so must depend upon the advisory dietitian or the visiting housekeeper. Dispensary and visiting-nursing associations should provide themselves, directly or through the co-operation of some other organization, with at least the advisory services of such a dietitian.

FOOD CLINICS INDISPENSABLE

Food clinics, in which dietitians can be consulted by nurses or general workers, and to which patients can be sent when necessary, are needed in large dispensaries and in connection with the Health Centers which are now being established so rapidly throughout the country. It is not desirable that these clinics should be confined to the restricted field of child nutrition.

IMMIGRANT DIETS AND AMERICAN FOOD

A dietitian has never been so honored, in college or out, as she will be by these foreign-born people when they realize her knowledge of their familiar foods. An Armenian storekeeper found a fellow countryman, a *chef* in an Armenian restaurant, suffering from indigestion. He said to him: "You come with me. I take you to the smartest woman you ever knew. She knows our foods, she tell you what to eat you feel better."

Part IV
AMERICAN AGENCIES AND METHODS

XIII

FIELD WORK WITH THE IMMIGRANT

THE evolution of the field agent, who in practice is either a visiting nurse, a social worker, or both, is a most significant recent development in medical organization. Fifteen years ago there were a few hundred visiting nurses in the United States; to-day there are probably over ten thousand.

The field agent has been the common denominator in the series of campaigns which have swept the country in the last twenty years, directed against some disease or group of more or less preventable diseases. Each of these has been initiated, guided, or pushed by national and by local organizations formed for the purpose. First in the field was the antituberculosis campaign. There followed in rapid succession national movements to reduce infant and maternal mortality, to control cancer, to control and prevent venereal disease, to promote school hygiene, dental hygiene, and mental hygiene. The striking fact, apparent after a slight survey of these various movements, is their common dependence for practical success upon the field agent. A similar development may be traced in the social-service departments of general hospitals and dispensaries.

Through the field agent the clinic or medical center reaches directly into the homes of the people. She does two things—she renders service and she educates.

IMMIGRANT HEALTH AND COMMUNITY

Bedside service to sick people brings a response in gratitude and sympathy which lays the foundation for effective educational work. The field agent means the beginning of a closer relation between the objects of medical and health work, the people, and the agents of such work—the doctors and administrators; she means that medical and health work ceases to be passive and begins to seek out its subjects; she means the beginning of localization, making a democratic neighborhood relation possible between those who serve and those who are served.

The success of the visiting nurse and medical-social worker in various practical efforts in curative and preventive medicine illustrates our principle that successful service must include the study of people as well as of technique, and should be localized as thoroughly as possible in order to develop personal relations on a democratic basis.

Hence the experience of field agents is important in developing the technique of health work with the foreign born. What are the problems of militant health agencies in dealing with the immigrant? What special problems do the visiting nurses and hospital social workers meet in the immigrant's home? What methods have been most successful? What difficulties are still to be solved? These are some of the questions answered by nurses, social workers, and executives of some fifty social-service departments, and about two hundred tuberculosis and other health agencies.

THE PROBLEM OF APPROACH

The first necessity of the field worker is to establish contact with the foreign-born family. In many cases

FIELD WORK WITH THE IMMIGRANT

these are recent immigrants who speak no English. Her object is to get them to do something or allow her to do something for them, for the good of their health. She must either convince them of the worth of her recommendations or inspire them with such confidence in herself that they will take her recommendations on faith. The nurse's most obvious difficulty is ignorance of the foreign language; a more fundamental difficulty is ignorance of the immigrant's social backgrounds and point of view.

The use of the nurse of foreign birth or parentage would seem on first consideration to solve both difficulties. One association writes:

We had a Polish nurse who was very helpful. She was Polish born, spoke German, French, Swedish, besides understanding a good many of the dialects.

Another statement comes from Denver, Colorado:

We have had only one nurse who was foreign born on our staff. She was Italian and of average ability, but very popular with her patients.

Further examination, however, discloses limitations to this service. Comparatively few foreign-born girls take nurse's training, either because they have not the prerequisite education or because other vocations take less preparation and yield a quicker return, or because national customs hold personal service in lower regard than clerical work or teaching. Among nationalities where marriage is considered the only respectable profession for women, any kind of paid work is regarded as demeaning.

Moreover, it seems to be a question whether foreign birth is in itself an advantage. It is the experience of

IMMIGRANT HEALTH AND COMMUNITY

several associations that nurses of foreign birth do not possess American habits of personal and home hygiene to a sufficient extent to push them with their patients against the inertia of generations. They lack conviction in their message and confidence in their pupils' ability to change. Sometimes the conviction is present, but accompanied by contempt of, or impatience with, their compatriots. On the other hand, it seems logical that a family inclined to adopt American ways would prefer to learn directly from a native American. Testimony on these points was received from a number of places:

We have had one or two [foreign-born nurses] and our experience has been that the families did not care for them and I do not think the nurses are as patient with people of their own nationality as with others.

We have one Polish nurse and have had Italian nurses, but we have found that these women do not have so great an influence upon their own nationality as does an American nurse.

The reason English-speaking nurses do better work than the Spanish-speaking is that their environment and training have given them an opportunity to see the advantage of their work.

Foreign-born nurses often have a very strong influence with their patients, but it is probable that they secure this, not through their foreign birth, but through their knowledge of the foreign tongue and customs.

BARRIER OF LANGUAGE

Native-born nurses, except for a relatively few, must overcome the language barrier by the use of interpreters and foreign-language literature. There is little

FIELD WORK WITH THE IMMIGRANT

organized provision for interpreters in this country. Therefore, the nurse must depend upon whoever can be pressed into service at the moment. Most frequently this is a neighbor or a child of the household, rarely a paid interpreter. Interpretation demands so much understanding, conviction, and sympathy, besides mere translation, that it is not surprising to find differences of opinion as to whether children or adults prove more satisfactory.

The case against the adult relative, or neighbor, may be stated as follows:

The question of a paid interpreter has been the most difficult one, for it is almost impossible to obtain an adult who will not incorporate her own ideas into the interpretation. It is imperative that the nurse understand some of the language with which she is dealing, if she is to meet with the greatest possible success. (Detroit, Michigan.)

Of course the difficulty in using an interpreter is their tendency to put their own construction on the sentence to be translated. (Worcester, Massachusetts.)

An exception is stated as follows:

It has been my personal experience that when a young couple are living alone they are usually anxious and willing to learn from us and the man makes an interested and faithful interpreter.

When such an interpreter is found, the nurse can do no better than to make use of him.

In families where the children attend American schools, speaking English at school, and the mother tongue at home, they are often the most available translators. In so far as the child is relatively free from old-country traditions and from motives of self-interest, he can truly render the message as spoken.

IMMIGRANT HEALTH AND COMMUNITY

The following statement comes from New Haven, Connecticut:

A great many nurses have always made it a point, whenever possible, to use a child interpreter, for by so doing the child was also learning a valuable lesson. Of course too young a child would not be used.

Using the child interpreter also has its difficulties, as brought out by the following:

Probably the chief difficulty is in having children interpret for mothers concerning matters which they do not understand and should better not know of. (Fitchburg, Massachusetts.)

We find that many times if what the mother tells the child to say to the nurse does not please the child she will not tell it. (Providence, Rhode Island.)

A suggestion of the happy mean comes from Springfield, Massachusetts:

We consider an intelligent child of fourteen a better interpreter by virtue of her schooling in this country and because she will give a more accurate interpretation than an adult who has learned our language in a general way and who also is apt to add his own interpretation and suggestions to what is said.

Great care, however, must be taken in using children as interpreters, lest the child develop an undue sense of importance. Too often the child who learns English and "American ways" at school, comes to look down upon the "old people" as far behind the times. A fine and wholesome family life may thus be broken up and nothing substituted in its place.

One thing obvious from the answers to our inquiries is that the question of interpretation has been taken too casually by the majority of visiting-nurse asso-

FIELD WORK WITH THE IMMIGRANT

ciations and other agencies, those who spoke of it in the least analytically being decidedly the exception.

The use of foreign-language literature is quite general among tuberculosis workers, visiting-nurse associations, social-service departments, and other health agencies. State departments of health, because of their educational and advisory functions, are notable among agencies which have developed the use of foreign-language literature extensively. The baby-welfare and tuberculosis campaigns, pushed by many state departments, have utilized foreign-language leaflets in Pennsylvania, New York, Massachusetts, Louisiana, Maine, and doubtless elsewhere. The recently developed campaign against venereal disease has led in several states to the printing of advice and instruction in many foreign languages.

The New York State Department of Health used foreign-language literature to reach the foreign born in connection with birth registration. Its methods are described by one of its officers:

Four years ago (1914) when the new vital statistics law went into effect posters were printed in several different languages calling attention to the law in regard to birth registration. At that time in addition to the posters we had exhibits in foreign languages and also lecturers and nurses who could talk to the foreigners in their own language. We also had the co-operation of local workers who were either of foreign extraction or who knew the language of the people with whom they came in contact.

The limitations of the printed word are serious, however. From New Haven, Connecticut, comes this report:

Our nurses feel that literature must be very brief and very much to the point or it will not be read.

IMMIGRANT HEALTH AND COMMUNITY

Others report that a pamphlet printed in English, even though it has to be read and explained to the parents by the children, accomplishes more in a home. We get from Buffalo a statement typical of points of view in other cities:

We find that if the Italian can read at all he can read English, and to some extent the same is true of the Pole.

The strongest statement of all comes from Akron, Ohio:

We have never used literature printed in foreign languages to any great extent. The Americanization movement rather discourages it because we wish the foreign people to learn our language.

It is fair to say that there are two sides to this question, or perhaps two stages. To reach the recent immigrant it is usually necessary to use his own language in speech and print, but as time goes on he should be encouraged and expected to venture into American life and speech.

Some personal knowledge of the immigrant's own tongue is of inestimable value to the nurse, even though the bulk of her conversation must be through an interpreter. To the immigrant fearful of the unfamiliar and the incomprehensible, what a ray of hope must be the visit of a nurse who speaks his familiar tongue, even if only a few words. The following comment is submitted as an instance of the importance of language:

We are fully 50 per cent French Canadian here in Manchester, and until I added two French-speaking nurses to our staff our work for the Metropolitan Life Insurance remained at a standstill.

FIELD WORK WITH THE IMMIGRANT

At the present time a few visiting-nurse associations are encouraging their nurses to take definite courses in the foreign languages which are chiefly spoken in their districts. Many nurses and social workers, however, have not time for extended courses in which the instruction is developed along literary rather than practical lines. The end to be achieved is the requirement, not of immediate fluency in Italian, Yiddish, or Syrian, but of enough words to build a bridge between the newcomer and the American, to develop and sustain a mutual interest, and to lay the foundation for the continual growth of vocabulary through the nurses' daily work. We have found nurses and social workers who have worked for years among one race without acquiring any of the language, and others who have learned more and more of it each year. The difference was that one set of people were given a start, while the others never were.

Of much practical assistance are phrase books giving the words and sentences frequently used in medical and health work. The *English-Italian Phrase Book for Social Workers*, by Miss Edith Waller, with its special supplement for the use of physicians, is a good example. There was published in 1916 *A Handbook of Phrases in Four Languages* (Italian, Bohemian, German, and English), especially for the use of district nurses. This was issued by the Visiting Nurses' Association of Cleveland, Ohio, under the auspices of the National Organization for Public Health Nursing. In 1918 the national organization itself published a smaller handbook of phrases in Spanish and English. The Visiting Nurses' Association of Topeka, Kansas, prepared a brief list of phrases for its nurses, "just to

IMMIGRANT HEALTH AND COMMUNITY

give them a start." The preparation of such phrase books can be carried out more efficiently by national organizations than by a number of local bodies. There seems every reason why they should take up this matter.

The subject matter of a phrase book should be suited to the special vocabulary of the work in which it is to be used. It would be unwise to have one phrase book prepared for the use of either teachers, nurses, or general social workers. The vocabulary would have to be so large that the book would be much less useful than would three separate booklets. The ends to be sought are the utmost practicality and brevity. Some of the published phrase books have failed to give instruction in pronunciation—a serious defect.

It seems a pity not to include in such a phrase book something about the backgrounds and characteristics of the people, even if it be only a single page. This is for the same reason that a conference with a representative of the immigrant group is the best introduction to a study of the group. The development of interest and understanding concerning the people will lead inevitably to some mastery of the language if even a slight start is made, but without such understanding the acquirement of the language can be little more than a required task.

No more suggestive and practical piece of work of this type has been done than that by the Rev. Francis A. Bimanski, one of the chaplains of Cook County Hospital, Chicago. This devoted worker among the Polish people felt keenly their isolation and loneliness in the great hospital. He also appreciated the difficulty experienced by the visiting staff, the internes,

FIELD WORK WITH THE IMMIGRANT

and the nurses in securing the necessary medical or social information from patients who spoke no English. So he set himself, in the face of many obstacles, to remedy this defect. He made a beginning by taking some simple questions and answers which had to be frequently asked. In order to ascertain the primary complaint of the patient, he developed the phrase:

"Pains?" "Where?" "Show with fingers."

Raising the money himself, he had a little slip printed with this heading, and its translation into Polish and half a dozen other languages, phonetically written so that anyone could come somewhere near pronouncing the words, near enough, at least, for the patient to understand. Any person who has tried to elicit the symptoms of a patient who can speak no English will appreciate the practical value of this.

Carrying on the same idea, he worked out a series of other practical questions, translated and printed phonetically in several languages. Some of the prints were made on large sheets, which could be posted in a ward or a clinic. He also prepared pocket-size leaflets of from four to sixteen pages, and made an endeavor to teach nurses and internes systematically.

These leaflets might be improved in certain details, but examination of them will be very suggestive to anyone who seeks to improve existing phrase books or develop still better ones. In every one of his leaflets, Father Bimanski included something about the people or peoples concerned. His practical experience had led him to the same conviction of which our study is so full, that knowledge of a people, and respect and sympathy for them, are the foundation

IMMIGRANT HEALTH AND COMMUNITY

for happier work with them, and for better results in professional service.

In learning the language of the immigrants, however, the aim must not be lost sight of. This is that English be the ultimate medium of communication. The American worker should use the foreign tongues only to bridge the first strangeness with a friendly familiar word. A wise caution is expressed in the following:

The nurse who speaks the language fluently has a distinct advantage over the other nurses if under the pressure of work that is bound to come to every public-health nurse she does not lose sight of the eventual naturalization of the patients. For the fusion of these people with the native born, as well as teaching right living, is our aim. (Detroit, Michigan.)

KNOWLEDGE OF BACKGROUNDS

More important than reaching the immigrant in his own language is reaching him sympathetically. This can be done best by showing an interest in the land of his birth. Miss Lillian Wald says of her early days on the East Side, "I could not speak their languages, but I could smile in fifty-seven tongues." This point was brought out by many answers to our inquiries:

The right kind of nurse can do very effective work even though she cannot speak or understand the foreign languages. Our greatest success has been with a nurse not speaking Italian, but picking up words and expressions, getting the background of the patients, their former environment, their holidays, and great men. (Shenandoah, Pennsylvania.)

A hospital social-service department in St. Louis states:

FIELD WORK WITH THE IMMIGRANT

It is advisable that my social workers have a most thorough knowledge of the backgrounds of the foreign born; necessary that they at least have a course in race history and race problems either in an accredited college or in a school for social workers.

The head of a social-service department in Philadelphia testified:

The well-equipped worker ought to have a knowledge of the conditions under which the foreign born lived at home, their employment, habits, recreation, education, religion, and traditions; why they came to this country; to what degree they have been exploited industrially; in what way their present environment differs from the old one, and the disadvantages and advantages of their present environment; a knowledge, too, of the historical background; the part the nation has played in the development of art, science, and religion. With this knowledge there ought to be a strong feeling for the whole human race as one family. We must recognize "The broad sameness of the human lot which never alters in the main headings of its history—hunger and labor, seed time and harvest, love and death."

Much should be added to the classroom instruction in immigrant backgrounds and characteristics. Lectures alone, without personal contact with immigrant families, are almost valueless. All good schools give the student, whether she be the prospective nurse, social worker, or dietitian, a certain amount of practical experience under supervision, and the best schools devote to this a considerable proportion of the student's time during the latter part of her course. It is not difficult to include contact with immigrants of different groups in this experience and to have these contacts interpreted by the teacher or by special persons familiar with the race groups.

IMMIGRANT HEALTH AND COMMUNITY

Medical and health work cannot, however, wait upon the training of new workers. The thousands who are already in the field, and who are working with immigrant groups, must get their knowledge of immigrant backgrounds without formal courses.

To a certain extent they can do this through literature. The pamphlets issued by the Americanization Committee of Cleveland exemplify a much-needed type of publication. Each booklet is devoted to a particular race group, prominent in the city: "The Slovaks of Cleveland," "The Hungarians of Cleveland," "The Poles of Cleveland." The booklets are brief, some sixteen to twenty-four pages, well illustrated with photographs, and contain material of local and practical interest as well as a historical account of the race in question.

The publication of such booklets by Americanization authorities in other cities is much to be desired. A national authority or committee might prepare interestingly written accounts of different race groups, and in co-operation with local and state authorities have these suitably modified in different states, cities, or sections of the country. Items of local as well as of general interest regarding an immigrant group are of so much value in these booklets that it seems questionable whether they should be uniform throughout the country.

There is a place for even briefer leaflets of the same character. Small folders designed especially for persons concerned with educational, social, or health work for the foreign born might well be prepared by such national organizations as the American Public Health Association, the National Tuberculosis

FIELD WORK WITH THE IMMIGRANT

Association, or the American Social Hygiene Association.

These leaflets should include a brief account of the people's European history, tradition, characteristics, their numbers, location, and activities within the United States, and might be combined, in some cases, with the phrase books designed to open the way in using the immigrant's language. Items of interest to a particular state or city could be added to this material by the local authorities. To instruct visiting nurses or hospital social workers by the use of leaflets alone would not take us very far, but it would be a move in the right direction.

A more important step would be for nursing and social-service staffs to hold a few conferences each year with leaders of different immigrant races, or persons who are familiar at first hand with these races. After all, nothing arouses more interest in an immigrant group than hearing it described by a man or woman of the right type who is close to it. Attendance at a single meeting of this kind has been known to change a nurse's or social worker's whole attitude toward a group of immigrants. The time and effort required to arrange such conferences for the staff of a visiting nurses' association, a social-service department, or a tuberculosis committee would be small in proportion to the great benefits that would be derived. It may be pointed out also that these benefits would be mutual, increasing the co-operativeness of the immigrants as well as of the workers.

Once the right start is made, the rest largely takes care of itself through the contacts of the daily work. These contacts mean little or nothing without a suffi-

IMMIGRANT HEALTH AND COMMUNITY

cient basis of interest and knowledge for them to be emotionally warm and intellectually understood; but once the field agent's interest is aroused, it is surprising how little information about the Poles, the Jews, the Italians, or the Lithuanians she needs as a basis on which to build further knowledge automatically.

Too much care cannot be taken that the attitude toward the immigrant is not based on the premise that we are right and he is wrong. A few associations express a wish, and many show a need, for more sympathetic understanding of the foreign-born patients. Witness such complaints as, "They don't seem to know anything about American customs or about tuberculosis."

When nurses complain that immigrants have too many children, that they seem to cling to their own customs, it shows a kind of provincialism and ignorance even worse than that of their patients. Especially refreshing, therefore, were the replies from two organizations who admitted that perhaps the difficulties were due to lack of knowledge and understanding on our part, an attitude of mind which could profitably be encouraged without any sacrifice of American standards. One executive recognizes this as at least one of the causes for failure in Americanization work. He says:

I think that your committee might do an immediately needed piece of work for public-health nurses if it would compile a list of books and magazine articles touching upon the problems of our foreign born by racial, occupational groups or any other way. If this list can be made of books which should be procurable either from a public library or a bookseller it would be all the more valuable. Doubtless there are such lists, but most of us don't know of them.

FIELD WORK WITH THE IMMIGRANT

This is a need less obvious, but more fundamental, than that of phrase books. Such knowledge of immigrant backgrounds is needed by the public-health nurse, the social worker, and, in fact, by everyone who has to deal with his foreign-born neighbor.

LOCALIZATION OF HEALTH WORK

Another suggestion is that we take the trouble to go to the foreign born with what we have to give, be it a baby clinic, a housekeeping center, or an English class. By locating it in his part of town we avoid the necessity of drawing him away from his familiar streets and buildings. One baby clinic in a Texas city trebled the enrollment of Mexican babies when it moved just a few blocks into the Mexican district. Another association reached the foreign children by sending a nurse daily to make inspection and give lessons in hygiene at a Polish parochial school.

The mother in her home, seldom, if ever, getting out to gatherings of any sort, is the hardest member of the immigrant group to reach, and often the slowest to give up her racial habits; yet in her position as homekeeper she has most to do with the health of her family. Taking our health work into her neighborhood is the surest way to get acquainted with her. If her headquarters are near by, the nurse makes more friendly visits, calling often to foster familiarity and affection.

Above all, our most hopeful approach is through the baby and the growing children, and these can be more easily reached by a neighborhood unit. Many replies indicate that it is considered practically im-

IMMIGRANT HEALTH AND COMMUNITY

possible to enlist the attention of mothers except through service offered to their babies and younger children:

A great many of the habits of the immigrant we have been able to change after getting the mother interested in our welfare association. I consider the infant-welfare station to be one of the biggest factors in Americanizing the foreign mothers that we can possibly organize. (Buffalo, New York.)

Others mention the Little Mothers' clubs, which teach the younger girls in the schools, as the best approach to the parents:

Teaching "Little Mothers' Clubs" seems to clear the way for Infant Welfare work, and we often find the children have ordered the mother to give the baby only boiled water if ailing and while waiting for the nurse to come. (Manchester, New Hampshire.)

Care must be taken to see that the children do not scorn their parents' habits, but recognize the good features in them. The public school, through co-operation between the school nurse and the teacher and through parent-teacher's meetings, can be a powerful factor in determining this attitude, and at the same time appeal to mother love, the strongest motive in the world, to effect changes in the habits of generations.

In local health work it is often possible to reach a foreign-born group through its own leaders. The co-operation of lodges, labor unions, and religious bodies of the foreign born has been sought by a small number of tuberculosis associations, twelve reporting definitely upon such endeavors. The co-operation of the priest is not infrequently referred to. In the

FIELD WORK WITH THE IMMIGRANT

somewhat slow and difficult task of securing the co-operation of immigrants or of their organizations, the primary need for democratic and sympathetic approach has often not been recognized. A notable exception indicates the right path.

In 1910 the Committee on the Prevention of Tuberculosis of the Charity Organization Society of New York, under the direction of Dr. Lawrence Veiller,¹ organized a special Italian committee. One of its first activities "was to get up a very attractive colored poster containing a picture of Venice from a famous painting, in very attractive colors, and then printing along on the side of the picture advice about tuberculosis, with reference to the nearest tuberculosis clinic for that district." This poster was also printed in reduced size, and distributed from house to house through the Italian tenement districts on the lower East Side of Manhattan.

Later [says Doctor Veiller] we transferred our activities to the newer Italian quarter on the upper East Side in the neighborhood of Thomas Jefferson Park, around 114th Street, after having first made a study of the need of a tuberculosis clinic for the Italians in that section. Having through that study developed this need, we then got the Health Department to establish a new clinic in that district and after that we then proceeded to build up business for the clinic by having our Italian visitor go from house to house and flat to flat with the small Venetian poster and on it a reference to go to the clinic in that district. Also, we gave them a little card of reference to the clinic. The result was that we in a very short time built up a big business for the clinic. It was a very practical and effective piece of social co-operation.

¹ The citations are from a personal letter from Doctor Veiller.

IMMIGRANT HEALTH AND COMMUNITY

This Italian committee continued for several years. After two or three years, the first interest having worn off, it became difficult to keep up the interest of the members of the committee, yet it was felt that the committee had by that time accomplished its purpose.

Doctor Veiller says, "It more than justified our expectations and more than warranted the expenditure we put into it."

SUMMARY

The material received from many health workers, visiting nurses, infant-welfare workers, tuberculosis agencies, and social-service departments, regarding methods of field work with the immigrant, may be summed up in several conclusions. The chief problem peculiar to work with immigrants is that of winning their confidence and reaching their understanding over the barriers of mutual unintelligibility in language, habits of life, and former experience.

1. The first necessity of the field worker is to find a medium of communication with the foreign born. The majority will have to depend upon interpreters. Since the employment of trained, paid, full-time interpreters is rarely practicable, some plan for securing them when needed must be developed. The chief point is that securing interpreters must be systematic, not haphazard. In field work, calling in or taking along one of a certain number of regular local interpreters is much better than calling in a chance neighbor or child. Valuable means exist here of building up organized co-operation with and among the foreign born. In so far as the field agents are equipped with enough knowledge of the backgrounds and charac-

FIELD WORK WITH THE IMMIGRANT

teristics of the immigrants to understand them in general, and with enough knowledge of the language to get the main points of the situation, interpretation will almost take care of itself.

2. Knowledge of the immigrant's language is a great help. It enables the health worker to use her interpreter intelligently; it also creates a feeling of confidence and appreciation on the part of the patient and of sympathy and readiness of approach on the part of the worker.

3. Experience in using foreign-language literature establishes two facts:

- a. Where literature of any kind is to be given those not speaking English, it should be in their mother tongue.
- b. Literature is comparatively ineffective except as a supplement to the spoken word. When so used, and when followed up by a personal conference with the professional worker, it helps to drive things home, to serve as a reminder, and to spread a little more widely the message given to the individual patient.

It is important that the persons preparing such literature be sufficiently informed about the subject matter and also have enough facility in the foreign language to present the ideas simply and interestingly. Such highly skilled persons are often beyond the command of a local organization, and this is one good reason why much of the foreign-language literature giving instruction in hygiene and in the care of various diseases should be prepared by national or state authori-

IMMIGRANT HEALTH AND COMMUNITY

ties who could make it available to an indefinite number of local agencies.

4. The children, because of their superior knowledge of English and of American customs, sometimes offer the readiest means of access to immigrant parents. Great caution, however, must be observed in utilizing children "to teach their parents," lest the disintegration of family life be encouraged.

5. Localization of field work, restricting one set of workers to a compact area with headquarters in the district, fosters familiarity and subsequent confidence.

6. To secure the co-operation of the foreign born themselves is one of the most important and difficult tasks confronting field workers.

7. The primary requisite for success in field work with the foreign born, the point upon which all other measures depend, is knowledge and understanding of the people, their backgrounds and characteristics.

XIV

THE HOSPITAL

THE hospital is an institution where patients are received whose illness requires that they remain in bed and receive more constant care and supervision than is possible in their homes. For the purpose of this study hospitals may be divided into two kinds:

1. The public-service hospital is a hospital, whether supported by public or private funds, which takes at least some patients as a service to the community and not merely in return for payment.

2. The proprietary hospital is run as a business enterprise. The term "private" should not be applied to hospitals of this second class because it is ambiguous, being used sometimes to mean supported by private as distinguished from public funds, and sometimes to mean maintained for private profit.

Hospitals are unevenly distributed throughout the United States. A disproportionate number are found in the larger cities and in the older communities of the East. The majority of these hospitals are of small size. There are 3,187 hospitals listed in the American Medical Directory of 1918 which, on the basis of information therein contained, have been tentatively classified as general hospitals of the first, or public-service, class. One thousand two hundred and thirty-nine of these, or 39 per cent, had 25 beds or fewer.

IMMIGRANT HEALTH AND COMMUNITY

There were almost exactly the same number (1,246) with from 26 to 99 beds. Only 702 hospitals had 100 beds or more. The number of private proprietary hospitals is much larger, but the great bulk are small, having 25 beds or less.

In discussing the relation of the hospital to the medical care of the immigrant we are practically limited to the public-service group, chiefly to the institutions of 100 beds or more. The most highly developed examples of hospital service are found in the large hospitals, particularly in those which are affiliated with medical schools and are university or teaching hospitals.

In view of the fact that a large number of northern Europeans have settled in the growing industrial communities of middle size and in the small towns and rural districts, it is significant that the 66 medical schools of the country are nearly all located in large cities, that the number of medical schools is likely to diminish rather than to increase, and that hospitals established and maintained in intimate co-operation with these schools can reach only a very small fraction of the population in each state. These facts are fundamental to a consideration of hospital service for the immigrant.

IMMIGRANT ATTITUDES

The service that hospitals can render the immigrant is in part dependent upon his attitude toward the hospital. This is brought out by interviews with the foreign born, both doctors and laymen.

A Polish doctor says:

THE HOSPITAL

Poles are decidedly opposed to going to the hospital under any circumstances or to allowing their children to be taken. To go to the hospital is to die, they think, because in their experience it has always meant the last resort. Aside from this, they lack confidence in hospitals. The strangest stories gain currency among them about practices in the hospitals and the doctors can't reassure them. They actually believe that patients die of neglect or are killed by "black medicine."

A Russian doctor says:

Russians are afraid to go to the hospital; they have known little or nothing of them in the old country, and the experiences of people of their own nationality in the hospitals of this country have not served to give them any faith in them, for they do not understand the treatments. Exaggerated stories easily gain currency. The lack of the language makes them feel strange and helpless.

An Italian doctor says:

The masses of the Italian people have a deep-seated prejudice against hospitals. It would be difficult to find the cause of it. I cannot understand it; it is like many of the superstitions of ignorant people. They say people are abused, or neglected, or killed in hospitals. The younger generation is of course getting away from such notions, but still I have to deal with many cases at home when I know recovery would be much more certain in a hospital.

The immigrant's attitude toward the hospital of course depends partly on his background and partly on his personality and immediate circumstances. If he has come from a district abroad in which hospitals are distant places to which only desperately ill people are sent, naturally he comes to America with a different notion than if he had been brought up in a

IMMIGRANT HEALTH AND COMMUNITY

large city well provided with hospitals. Once located in an American city, the immigrant and his family may be in continuous good health, but they are almost certain to hear about a neighbor or friend who has been taken to this or that hospital because of accident or illness.

Those who visit a patient report their impressions. The patient himself returns and does likewise. Should the patient die at the hospital, a feeling of fear or repugnance may be strongly confirmed among his acquaintances. Most hospitals give even the sophisticated visitor a sense of being surrounded by very busy, presumably very efficient, doctors, nurses, and employees, who are passing rapidly from one duty to another and have little time for *him*. When to the intrinsically depressing features of a hospital are added unfamiliarity with the language spoken there, and a sense of isolation and helplessness, the immigrant may be pardoned for sharing what an American visitor to many hospitals described as "a sinking feeling in the chest." It is easy to understand how the impressions of the individual immigrants quoted below were acquired. A Lettish immigrant reports:

Does not trust hospitals or dispensaries, especially city hospitals, which many of the men from the factory had been sent to when different accidents happened. One or two of them had died and the family and neighbors look upon all hospitals as a place where one goes to die.

From two Lithuanians come the following testimonies:

All hospitals are the same to Mr. M. "When men are hurt in the factory they are sent there, and if the young doctors do not practice on them they live, but otherwise

THE HOSPITAL

they die." Mr. M. had no other occasion to use doctors. When he had a cold and sore throat he told the druggist what the trouble was and he gave him some medicine. "Of course the druggist knows what is good for you."

Had to go to hospital for spinal trouble. Did not like the hospital, as they were not kind to her. They spoke in a foreign tongue which she could not comprehend.

The attitude toward hospitals revealed in one hundred and fifty interviews with doctors, and about an equal number with individual immigrants, could be summarized in the following opinions:

A strange place.

A place in which I cannot understand what people say, nor be understood.

A place where doctors practice on you, especially young doctors.

A place where people die.

A place where I cannot get the food I like or am used to.

A place where either I have to take charity or pay more than I can afford.

These items are listed in about their order of frequency or importance, so far as can be judged from the material at hand. Obviously the degree of strangeness varies with the individual and his previous experience with hospitals. An immigrant who speaks even a little English is far less isolated and unhappy in a hospital than one who may be shut off for weeks with people who cannot speak a word of the only tongue he knows. The education or intelligence of the patient, as well as his previous experience in medical institutions, will determine whether he believes the false stories about doctors "practicing on patients,"

IMMIGRANT HEALTH AND COMMUNITY

and whether he fears hospitals for the reason that the sailorman in the story feared beds—because most people die there.

Dislike of accepting charity is a psychological barrier between the immigrant and the hospital, although the feeling is not so strong against medical charity as against material relief. On the other hand, most hospitals have only a few low-priced beds, and the so-called ward rate seems, and often is, a considerable sum to the wage earner. The hospitals supported by public funds, and the large endowed hospitals, present no financial obstacles, but most of our middle-sized and small communities have as yet an extremely limited number of free or low-priced beds.

Not even the educated layman can be expected to appraise the professional work of hospitals according to standards of medical efficiency. Their opinion is necessarily based upon their personal judgment of the thoroughness and rapidity of their cure, and the comfort and pleasantness of their stay in the institution. To what extent can the American hospital create a satisfactory human relationship with the foreign-born patient? So far there is little evidence that large hospitals have adapted themselves to the needs of race groups. The objections to hospitals urged by individual doctors and immigrants throw light on some of the difficulties.

In so far as these are based on lack of confidence, the only remedy is to change the immigrant's attitude. This is done by the slow process of gaining his confidence and ousting superstitions and rumors by demonstrating the benefits of prompt and adequate medical care. But the difficulties that arise from such

THE HOSPITAL

causes as dislike of strange food and lack of a means of communication can be met only by special changes in hospital procedure and administration. These all too often are found to be entirely lacking.

DIETS FOR THE FOREIGN BORN

All hospitals of any size have dietitians. In some hospitals the dietitian has direct responsibility for the menus of private or semiprivate cases only, while the menus for ward cases are made up by some subordinate or cook. Yet even in such hospitals the dietitians' influence over the general menu is very considerable. In any case, the dietitian is the trained professional person through whom the hospital must work in altering or advancing its dietary standards and methods. Twenty-six representative dietitians whose names were supplied by an official of the American Dietetic Association were asked whether they had worked out and put into practice any special diets for foreign-born patients in their hospitals; whether they felt that foreign-born patients presented a dietary problem, and whether they thought it desirable and practicable to adapt their dietary to such patients.

Of the thirteen who replied, nine were doing nothing in this matter. One said that they had very few foreign-born patients in their hospital and therefore no problem of this kind. Two had previously maintained a *kosher* kitchen for Jewish patients, but had discontinued this. One dietitian said they were serving fish on Fridays for Catholic patients, the majority of whom were foreign born. Many hospitals do this without regard to nationality of patients. A few die-

IMMIGRANT HEALTH AND COMMUNITY

titians realized the importance of the problem. One of these said:

The only information which I can give you in regard to special diets for foreign-born patients is that we consider each patient as an individual and, as far as is practicable, arrange the diet in accordance with his previous food habits. We have here Italian patients, Irish patients, and patients with Jewish religious preferences. The student dietitians are instructed in the dietary habits of these people, and they regulate their menus accordingly. For the patients on regular house diet we make no distinction of nationality or religion. As we have only about two hundred and fifty patients scattered over some fifteen wards, we have not found it practicable to differentiate in the food. I think the idea is very splendid if the percentage of patients is high enough to warrant considering national food customs, as the psychological effect of food upon the patient has much to do with his recovery, and it impresses me that hospitals should take this into consideration. If I were to handle the food proposition for a hospital having Italian patients I should have an Italian cook.

The president of the American Dietetic Association, referring to this inquiry, said in a letter:

We have many foreign-born patients in our various hospitals who do not react favorably to treatment, especially dietotherapy, because they are unwilling to eat the food provided. Even if they do submit to treatment in the hospital, as soon as they go home they again take up the use of the food to which they are most accustomed.

Appetizing food contributes to the medical cure of the patients as well as to their comfort and happiness. This is particularly true in hospitals receiving chronic cases and in tuberculosis sanatoriums. A recent report of a committee of the Conference of State and Provincial Boards of Health said:

THE HOSPITAL

The sanatorium should not be considered primarily either a hospital or a boarding house. It should be so conducted as to make the patients satisfied and willing to stay. It should be borne in mind that happiness is essential to the recovery of the tuberculous.

There are very considerable difficulties in adapting a hospital dietary to foreign-born patients. Several different nationalities may be present in the hospital at the same time, each represented by a varying number of patients. Considering, however, the importance of the food problem, it is surprising that a selected group of professionals in charge of the diet in a number of leading hospitals should have given apparently so little thought to the problem and made so little attempt to solve it.

Judged by the food test, the American hospital has not made any noteworthy effort to adapt itself to the foreign born. Chapter XI of this book, devoted to the food problem of the foreign born in relation to health, presents certain material and practical suggestions which bear upon the hospital dietary.

USES OF INTERPRETERS

Another point at which American hospitals can be adapted to foreign-born patients is in the use of interpreters. The hospital, as well as the visiting nurse, must find some way of communicating with the patient who speaks no English; but in the case of an institution to which the patients all come, it is a simpler problem to furnish interpreters than to the individual nurse who visits many homes. It is relatively so simple an administrative problem that it is hard to

IMMIGRANT HEALTH AND COMMUNITY

believe so little has been done in the country to meet it.

A list of 30 well-known hospitals was prepared, each located in a city with a large immigrant population, and each known to be receiving a considerable proportion of foreign born. Inquiry was made, usually by personal letter, in a few cases by interview.

Reports received from 21 of the 30 reveal the following condition. One hospital employs 1 paid interpreter. This is one of the largest municipal hospitals in the country, with about 2,000 beds and a very large out-patient department. Of course, the employment of a single interpreter in an institution of this size, which receives patients from practically all immigrant races, is almost humorously inadequate. Fourteen of the 21 hospitals call upon employees or patients to interpret in various languages as needed. Five hospitals are not doing anything at all about interpreters, except occasionally.

Of the 14 hospitals which depend on patients or employees, 4 say that the method is not satisfactory in meeting their problem; 10 express themselves as reasonably satisfied with the scheme. In 2 of these 10 cases the so-called "star employee" is mentioned, some one who has been with the hospital quite a while, who is able to speak a number of languages, and who is called from his regular job, when necessary, to interpret. One large hospital has an arrangement with the United States Immigration Office and some local organizations of the foreign born to supply interpreters whenever needed.

These 21 hospitals are all large institutions, selected because of their location in foreign-born communities.

THE HOSPITAL

Their work naturally suffers from the inadequate system of interpretation. Patients' names and addresses are often obtained with difficulty or inaccurately. The medical history is taken under great risk of error or omission if the recorder has no knowledge of the immigrant's language and no satisfactory interpreter. The barrier of language raises serious obstacles to maximum efficiency in the administrative or medical work of the hospital. This is recognized by a considerable proportion of the superintendents of these 21 hospitals. Many, however, point out the difficulties in the way of securing satisfactory interpreters. One says:

We do not employ paid interpreters, but have to struggle along the best we can by utilizing employees or other patients for the purpose. Our experience in the matter is that the need of interpreters is very irregular and widely distributed over many languages and dialects, and we have been unable to formulate any working plan that will basically meet our needs and justify a definite salary schedule to cover the problem. Hence, in making our engagements with employees we try to bear in mind our need of interpreters when talking to applicants.

Another says:

I took a census of the hospital at one time and found we had as patients persons speaking fifteen different tongues, and it would take several interpreters to cover all of these languages. While we have been inconvenienced at times, we usually get on very well. For instance, I have an Italian orderly in our receiving ward, and we have had a floor polisher who speaks two or three of the Slavic dialects. We seem to have no difficulty in handling the French and German. There is, of course, some objection in taking a man from his work to do interpreting, and yet it is less

IMMIGRANT HEALTH AND COMMUNITY

expensive than having a special interpreter. I think that I can safely say that for a considerable time our records have not suffered from the fact that we could not get a history on account of the language.

These two letters point out some practical reasons why hospitals have so generally failed to employ paid interpreters, and have depended so largely upon employees or patients who speak the needed languages. However, the admitting officer or the hospital internes must secure information concerning the medical and social history of the patient which an uneducated interpreter is often wholly unable to obtain. Whether in this respect or in meeting the patients' human needs, good interpretation can rarely be secured by this casual system.

Another attempt at solving the problem is illustrated by the following statement from a large general hospital in a Middle Western city.

We do not employ paid interpreters. Occasionally we do use employees or other patients, but in the majority of instances we rely upon other associations in the city for this work. The various councils give their services gratis in cases of necessity; and other institutions, such as the House of Friendliness, the Americanization Society, and similar organizations, will send interpreters to the hospital on request, who give their services without charge. We have found this arrangement to be very satisfactory, but I imagine that in some of the larger cities where this problem is a more difficult one the question of a paid interpreter would receive very earnest consideration.

It is apparent that in overcoming the language barrier a certain number of hospitals have made a distinct effort, and the hospitals show up much better

THE HOSPITAL

in this respect than in dealing with the food problem. Yet it is again apparent, generally speaking, that hospitals have dealt with the problem of interpretation only as a succession of incidental emergencies which had to be met as well as possible, on the spur of the moment, by utilizing employees or patients without any systematic plan.

One reason that even large hospitals have considered it financially impossible to maintain a corps of paid interpreters has been their failure to realize the full use to which these might be put. Hospitals having large out-patient departments, with many patients who speak no English, have too often regarded them as a subsidiary or unimportant element in their work, and starved them financially. Taking the patients of the hospital and the out-patient department together, the number of those speaking a given foreign language is sometimes sufficient to require the entire time of an interpreter. The use of full-time interpreters, however, must necessarily be limited to very large institutions.

Smaller hospitals should solve the problem of interpretation by depending upon specially trained nurses or social workers or upon outside organizations interested in or composed of the foreign born. The latter should be encouraged to visit patients of their own race who have no other friends, and to help with difficult and special cases where interpretation is beyond the power of the hospital employees. Enough hospitals use this sort of outside co-operation to show that it is gladly provided by immigrant organizations and by American immigrant-welfare societies, without cost to the hospital and with mutual benefit. Such an

IMMIGRANT HEALTH AND COMMUNITY

arrangement will promote general understanding of the hospital among the foreign-born groups.

SOCIAL-SERVICE DEPARTMENT

In addition to the special adaptation necessary to overcome the difficulties of diet and language, every hospital receiving immigrants should have a social-service department to establish human relations with each patient. Yet despite the fact that all leaders in medical and public-health work to-day recognize the necessity for social service in hospitals, there are only some three hundred hospitals in this country which have such departments.

Such a department can work effectively only when it is intimately associated with the hospital administration in general, and not an isolated and subsidiary element helping individual patients whose needs have attracted special attention. The head of the department should be directly responsible to the hospital superintendent. The workers should be chosen for their skill and training in dealing with the personal and social problems of people. The department should be charged with special responsibilities for foreign-born patients; not merely case work in the wards, but also certain functions at the admission desk of the hospitals and the development and maintenance of effective co-operation with certain outside agencies.

At the admission desk it is important to obtain a considerable amount of information regarding the patient's personality, family, occupation, and resources, for the sake of the hospital's medical work and financial

THE HOSPITAL

returns, and also for the sake of the patient's care and after-care. It is often impossible to secure all these necessary facts at the moment when a very sick patient is admitted, but the deficiency can usually be supplied later. The facts gathered by the social worker at the admission desk must be put to a much broader service than merely to determine what the patient can pay the hospital for care. When properly secured, such knowledge furnishes hospital and patient a basis for mutual understanding and for the best medical and social results.

This work for the foreign born should be in the hands of some one who is able to speak at least one of the foreign languages common among the patients, and who has studied the backgrounds and characteristics of several immigrant races. It should be her responsibility also to help and encourage various hospital employees, nurses, other members of the social-service department, and internes, to secure knowledge about the backgrounds and characteristics of the chief immigrant groups. It should be made apparent that thus better histories can be obtained, better co-operation of the patient secured, and better medical results achieved. These measures should have the support not only of the hospital superintendent, but of the chiefs of the medical staff.

The same individual of the social-service department should develop co-operation with outside immigrant organizations, with immigrant welfare societies, or with both.

Most hospitals have been founded primarily for the care of acutely sick patients. The attention of their medical and administrative staffs has been cen-

IMMIGRANT HEALTH AND COMMUNITY

tered upon the outstanding items of disease. The need for after-care of patients following discharge from the hospital, for social service, and in general for the development of relationships between the hospital and the community outside has been slow of effective recognition in most medical institutions.

Hospital organization is generally of a somewhat rigid and military character. This is true not only in the operating room, where such might be expected and necessary, but in the general administration of the hospital. Hospitals have rarely functioned in close co-ordination with other organizations in a general community scheme for medical service. The usual unresponsiveness of hospitals to the special needs of foreign-born patients is merely one illustration of this characteristic.

Anyone even slightly familiar with hospitals can call to mind numerous instances of devoted attention by doctors and nurses to individual patients, and of much personal interest in their welfare. Grave or unusual illness calls forth ready and unstinted response. A patient whose personality is appealing naturally receives attention and evidence of interest irrespective of the seriousness of his case.

It is, however, the duty of a hospital organization to provide for the average patient in human as well as in technical medical ways. Imagine an Italian or Pole who lies ten days or three weeks in a ward amid strange surroundings, unable to speak English. He receives food which is unfamiliar and often distasteful, however well prepared from the American point of view. Perhaps he is without friends who can talk

THE HOSPITAL

to him even at the necessarily infrequent periods when ward visitors are allowed.

Is not such a patient humanly pitiable? Must not the promptest post-operative convalescence, or return to health after any serious illness, be retarded by such conditions? The best medical results for the patient require that he comprehend the doctor's directions as to diet, work, and regime of life, after he is discharged from the hospital. Failure to understand these directions may mean that much of the hospital's effort is wasted.

IMMIGRANT HOSPITALS

Some of the objections expressed by immigrants are met by hospitals run by members of their own nationalities. In several large cities immigrants of a given group, who have been in sufficient numbers and possessed of sufficient means, have developed special hospitals for their own people.

The Jews have established their own hospitals in most of the large centers of Jewish population. The dietary laws of the Jew furnish a special reason why the orthodox Hebrew objects to going to "American" hospitals. It is notable, however, that most of the larger hospitals put up and supported by Jewish people do not provide a strictly *kosher* diet, as food prepared according to the Jewish dietary laws is called. This is partly because of practical culinary difficulties and partly because these hospitals have in most instances been put up and are chiefly supported by groups of Jews who no longer observe the dietary laws strictly, if at all. On this account a movement is on foot in several cities to establish hospitals in

IMMIGRANT HEALTH AND COMMUNITY

which there is strict conformity to the Jewish dietary regime. In New York several *kosher* hospitals are well established. In Chicago the gradual rise in numbers, wealth, and influence of the orthodox Jewish immigration has recently resulted in a similar *kosher* hospital independent of the long-established Michael Reese Hospital.

In New York City we find the Italian Hospital. In several other cities where the Italians are newer and not so numerous as in New York, a number of efforts can be traced to found such hospitals, supported by and for Italians. There are hospitals supported by Poles or closely associated with Polish groups in Chicago, Detroit, Cleveland, Buffalo, and elsewhere. The Japanese colony in San Francisco is developing plans for its own hospital. The desire of the Japanese to come close to the American community is illustrated by their efforts to affiliate this proposed hospital with the University Hospital in San Francisco, thus providing opportunities for well-trained Japanese physicians, while also utilizing the services of American physicians of standing.

In smaller communities individual physicians maintain small private hospitals for people of their own race. The demand of the older generations for a hospital run by their own people, and furnishing their familiar foods, is often reinforced by the desire of doctors of the same race to have opportunities for hospital work and experience which most of them cannot secure at the "American" institutions.

The endeavors of foreign-born groups to develop their own hospitals should not be interpreted as merely a desire to perpetuate their own nationality in this

THE HOSPITAL

country or to keep their people from contact with America. The establishment of Jewish, Polish, or Italian hospitals springs rather from the failure of nearly all American hospitals to adapt themselves to the special demands of the immigrant.

NEED FOR A COMMUNITY PLAN

The desirability of separate immigrant hospitals must be finally judged by its effect upon the best medical service to the community. Many small unrelated hospital units, each serving a special group, are not so efficient as a smaller number of large related units.

If a community has ten hospitals of from fifty to one hundred beds, each can command only a limited amount of the highest grade of medical service in the various branches of modern medicine and surgery. Most of them will find it hard to provide adequate laboratory and X-ray facilities and other expensive but necessary diagnostic and therapeutic equipment. They cannot readily secure the best grade of skill for their executive officer, for the head of the nurses' training school, or for the various housekeeping departments.

The location of each is likely to be planned independently, without relation one to another or to the needs of the community as a whole. The distribution of beds among the various types of medical and surgical service cannot be nearly so effective in ten small independent units as in three or four large ones.

It is difficult to bring ten small institutions into effective co-ordination one with another and with the outside medical and health agencies of the community.

IMMIGRANT HEALTH AND COMMUNITY

This is particularly true if several of these ten hospitals have special affiliations with race groups.

There must be a hospital plan for the community as a whole. The scheme for the town of ten thousand will differ radically from that for a great city, but no hospital can work at any problem, such as adaptation to foreign-born patients, with full effectiveness, unless most or all of the hospitals of the community are working with it. Such a community plan is discussed in a later chapter and applies to hospitals as well as other institutions.

At the opening of this chapter hospitals were classified under two fundamental types—public service and proprietary hospitals. The direct bearing of this study has been obviously upon hospitals of the first class; but in many large cities a considerable number of the hospitals are proprietary, and not a few of the smaller communities have no other hospital facilities. Clearly, a hospital which is established as a business enterprise can serve only those who can afford to pay a profit as well as a price for their care. Individual charity cases can be taken but rarely.

Proprietary hospitals cannot be expected to adapt their service to any special group of patients except on a business basis. Either the community must establish its own hospital or else arrange with one or more of the proprietary institutions to take part-paying or free cases at public expense. Such arrangements are not infrequent, the proprietary hospital receiving a per capita return for this public service from the municipality, the county, or an industrial establishment.

Such arrangements, however, do not render the

THE HOSPITAL

administration of the hospital sufficiently sensitive to community needs and to the requirements of particular types of patients, the foreign born among others. The only adequate remedy for this situation is the relegation of the proprietary hospital to its proper sphere of serving the well-to-do, and the development in all communities, or at centers accessible to all, of hospitals founded primarily on a public-service basis.

XV

THE DISPENSARY

THE increase in the number of dispensaries in the United States during the last twenty years has been one of the outstanding features in medical and public-health work. The earliest dispensaries, as the name implies, were places for distributing medicine to the poor. The modern dispensary includes a group of clinics for treatment in most or all of the chief specialties of medicine and surgery. The giving of medicine is now incidental. The modern dispensary is a place for organized, or institutional, medical service to patients who are able to be up and about. It is an institution complementary to the hospital, whose patients are in such condition that they must be in bed.

Most of the larger dispensaries are branches or, as they are called, out-patient departments of hospitals. Some of equal size are independent of hospitals. The growth of these institutions has been very considerable; at the opening of the twentieth century their number did not much exceed one hundred, whereas in 1917 there were about nine hundred in the United States.¹ The greater number of these were in the larger cities, particularly in the East and Middle West.

¹ Davis and Warner, *Dispensaries, Their Management and Development*, pp. 4-36.

THE DISPENSARY

Even more striking has been the development of the public-health dispensaries, established as the outcome of one or another of the militant health movements, such as the antituberculosis or infant-welfare campaigns. These clinics are usually local in their range of operation, and small compared with the large dispensaries treating general diseases. They were practically unknown before 1900. A few tuberculosis clinics had been started previous to that year—not more than twenty in the whole country. By 1917 there were estimated to be thirteen hundred of these various special dispensaries, and the number was greatly increased during the war, owing to the stimulus given to campaigns against infant mortality and venereal disease.

Some of the public-health dispensaries confine their attention to preventive and educational work, such as advice to mothers concerning the care of babies and the supervision of baby feeding. But the tuberculosis, venereal disease, and mental clinics, and to a greater or less extent the infant-welfare clinics themselves, diagnose and treat disease as well as push educational and preventive measures.

It is important to bear in mind the general distinction between the large, centrally located dispensary, usually an out-patient department of a hospital, treating patients in many specialties of medicine and surgery, and the public-health clinic, usually drawing its patients from a limited area and confining itself to a special branch of work. A third type combines features of the first two. It is the dispensary of moderate size, including a certain number of specialties as well as general clinics, and reaching a more or less

IMMIGRANT HEALTH AND COMMUNITY

comprehensive, but still definitely localized, area. The term "Health Center," which is now heard so frequently, suggests a combination of various forms of medical and health work, such as a number of different public-health clinics in the same building, either with or without clinics giving treatment in various branches of medicine.

Dispensaries have differed from hospitals significantly in the matter of clientele. The hospital generally accepts patients from all economic classes: those who can pay whatever is demanded go to individual rooms as private patients; those who can pay nothing or only the so-called ward rate go into large wards; persons in middle circumstances pay enough for small wards or semiprivate rooms, if the hospital has such.

With a very few notable exceptions dispensaries have limited their clientele to those who can pay little or nothing for medical service. Nominal fees are often charged, ten cents or twenty-five cents a visit, with or without small extra charges for medicines or special treatment; but the dispensary has been regarded, and has generally been operated, as an institution for medical relief of the poor, rather than an institution providing medical care for every social class, and receiving from each class according to its means. Considering the difficulty which many immigrants have in obtaining or in paying for adequate medical service, one might feel that the dispensary was peculiarly called upon to serve the immigrant.

We have seen something of the immigrant's attitude toward hospitals. Many of the same objections are raised against dispensaries. The distance and strangeness of the place, the inability to understand or to

THE DISPENSARY

make oneself understood, and the fear that doctors "practice on you," are all brought out in immigrant testimonies. The long waiting before treatment is an additional objection to the dispensary. This becomes a serious problem for mothers, when children must either be brought along or left at home in the care of a busy neighbor or of children too young to take the responsibility. A Polish woman says:

Mrs. C. was referred to the dispensary by the public charities. She had complained of blurring eyes and splitting headaches. The doctors in her neighborhood could not help her and the neighbors had told her all they knew about patent medicines. Since she came to the dispensary she felt better, but it is so far and the car fare is expensive. Besides, not being able to read and write, she does not know what car to take, and the neighbors, although they were willing to come with her the first time, find that they are too busy to give all the morning. Then, of course, she cannot speak English and does not like to explain to everyone why she cannot pay. So she had rather stay at home and suffer.

From an Italian comes this testimony:

Family have used several dispensaries. Her husband for his eyes, she for herself and her children. When her children were babies she used to go there for their feeding, as she could not nurse them. She does not like their methods of treatment. She feels that the doctors are students and experiment on the patients. Her child didn't improve, so she took her to a private doctor. Then, too, she says that one has to waste so much time waiting before being treated. On the whole, though the private doctor charges more, one remains more satisfied.

A Ukrainian doctor says:

Attitude toward dispensaries much the same as toward hospitals: they feel very strange and lost; the doctors do

IMMIGRANT HEALTH AND COMMUNITY

not speak the language; and when the history of a case has to be taken through an interpreter there is so much talk going on which the patient does not understand that he goes away bewildered and discouraged. The dispensaries are not usually very near, the hours may not be convenient, there is the long waiting in line, and again the suggestion of charity.

A Jewish doctor says:

In regard to the dispensaries, the Jewish attitude is quite different, and the people flock to them. They know they will receive the care of a specialist, a professor, and they are only too glad to avail themselves of the opportunity. There the mother can go into the clinic with the child and is permitted to talk and explain herself freely.

USE BY IMMIGRANTS

In spite of these attitudes, one of the striking features of dispensary work is the wide variety of nationalities cared for and the large proportion of foreign born among the patients of many typical institutions. Thus, at the Boston Dispensary, which receives about 35,000 patients a year in its out-patient clinics, 34 different nationalities were represented during one recent year; 45 per cent of all the patients were foreign born, but 30 per cent additional were the native-born children of immigrants, only one fourth of the total clientele being of native stock. This proportion is not dissimilar to that which obtains in the local population.

There are, of course, some large dispensaries, in New York City, for example, where, because of the neighborhood or the racial affiliations of the dispensary, a vast majority of the patients are of a single racial

THE DISPENSARY

group. But the polyglot nature of the assemblage in the admission hall cannot fail to impress the visitor to almost any of the larger dispensaries in New York, Chicago, Baltimore, Philadelphia, Cleveland, St. Louis, or San Francisco.

With a view to understanding the order and rate of the immigrant's acquaintanceship with American medical resources, it is interesting to ascertain the relative use of dispensaries by different racial groups. Some valuable figures have been obtained from one of the largest dispensaries in Chicago.¹ Out of 2,535 consecutive cases, 1,055 were from 6 chief immigrant groups:

TABLE XXX

NUMBER AND PER CENT OF 1,055 CASES TREATED BY THE CENTRAL FREE DISPENSARY, RUSH MEDICAL COLLEGE, BY NATIONALITY

NATIONALITY	NUMBER	PER CENT
Polish.....	343	32.5
Jewish.....	333	31.6
Italian.....	182	17.3
Bohemian.....	115	10.9
Lithuanian.....	57	5.4
Greek.....	25	2.4
Total.....	1,055	100.0

It will be noticed that the number of Jews and Poles are nearly equal. Investigation of the sources from which the patients came, or of the reasons for their coming, disclosed the following facts. More than 55 per cent of the Poles were sent to the dispensary by

¹ The co-operation of Mr. John E. Ranson, superintendent of the Central Free Dispensary of Rush Medical College, is gratefully acknowledged in this connection.

IMMIGRANT HEALTH AND COMMUNITY

some agency, usually the Board of Education. Among the Jews, on the other hand, only 13 per cent had come from agencies, the large majority having come to the dispensary on their own initiative. The Italians occupy a middle ground between the Jews and the Poles, 45 per cent having been referred by an agency. Among the Polish patients only 10 per cent were forty-five years of age or over, and 45 per cent were children of, or under school age, who came to the dispensary either to secure medical examination for working papers or because the school doctor or nurse had referred them for medical care. The percentages among the Bohemians and the Lithuanians were practically the same as for the Poles. Among the Jews, 20 per cent were over forty-five, and only 10 per cent were children.

The percentage of Jewish patients among the total patients of the Boston Dispensary was found to be just about twice as great as the proportion of Jews in the city population.

Figures secured in the study of the dispensaries of New York City, conducted by Dr. E. H. Lewinski-Corwin, under the auspices of the New York Academy of Medicine, and generously placed at our disposal, showed the type of treatment secured by 3,536 sufferers from various ills in New York City, by nationality. The number using dispensaries is compared with the number using hospitals by race (Table XXXI).

From all these figures it is apparent that of the three large recent immigrant groups, the Jews are far and away the greatest users of dispensaries; the Poles and other Slavs use them least; the Italians occupy a middle division. Long residence in the country in-

THE DISPENSARY

fluences the situation, by increasing familiarity with the language and with the existence and location of the dispensaries themselves. The nature of their work gradually becomes known through the stories of friends and acquaintances. Individuals and races differ obviously in their readiness to seek opportunity. The keenness of the Jew in this respect, combined with a sensitive organism which impels him to seek

TABLE XXXI

NUMBER AND PER CENT OF 3,536 NEW YORK CITY CASES USING HOSPITALS AND DISPENSARIES, BY NATIONALITY

NATIONALITY	TOTAL NUMBER OF CASES	USING DIS- PENSARY		USING HOS- PITAL	
		Number	Per Cent	Number	Per Cent
Irish.....	209	40	19.1	19	9.1
U. S. A.....	596	99	16.6	36	6.0
Negro.....	193	25	13.0	20	10.4
Hebrew.....	575	69	12.0	67	11.7
German.....	215	20	9.3	14	6.5
Miscellaneous.....	243	18	7.4	19	7.8
Italian.....	844	26	3.1	44	5.2
Slav.....	661	14	2.1	15	2.3
Total.....	3,536	311	8.8	234	6.6

prompt relief from illness or suffering, may account, at least in part, for his occupying first place numerically in the immigrant clientele of dispensaries.

One of the motives which lead persons to dispensaries for medical care is economic. They may go because they haven't the money to pay for a private doctor, or because they have been to a private doctor and have been dissatisfied with their treatment and have very little ready money left. The desire to secure high-class medical treatment is another power-

IMMIGRANT HEALTH AND COMMUNITY

ful motive. They seek the dispensary because the name of a famous doctor is attached to it; or something is the matter with the eye or other special organ, and they know they cannot afford the high rates charged by specialists at their private offices. The dispensary, in fact, offers the only opportunity for most persons of small means to see specialists.

Other motives operate to keep both native and foreign born away from dispensaries. The dislike of receiving charity is one; others are the inconveniences of waiting, of being crowded, of having less privacy than in a doctor's office, all conditions frequently found in dispensaries at the present time. The special deterrents caused by barriers of language, ignorance, superstition, or fear, have often been referred to.

The dispensary cannot be regarded as merely an institution for furnishing medical charity. It is an institution for furnishing medical service to those who need it, and from this standpoint it is not only its privilege, but its duty, to adapt itself to their needs. Keeping in mind the immigrant point of view, let us ask what dispensaries in America have done to adapt themselves to the immigrant, and what they can do; what has been the point of view of doctors, nurses, social workers, and administrators toward the immigrant; what their understanding of his personality and needs; what their effort to give him what he needs in an acceptable manner?

MEETING THE NEEDS OF INDIVIDUALS

Many hospitals suffer from institutionalism or over-organization along military lines, and consequent inflexibility to the needs of the individual. Dispen-

THE DISPENSARY

saries are liable to the opposite defect, of under-organization; a loose and careless manner of running. Hundreds of patients pour into the waiting room; their names and addresses are hastily entered by a clerk; they are moved along as rapidly as possible to the waiting rooms of various clinics; they wait until the doctors arrive and then until the doctors are ready to see them. Sometimes they wait a long time; see the doctors, who are perhaps in a hurry; some get advice; perhaps understand some of it; very likely get a prescription for medicine; get the medicine; go home. The three outstanding impressions given by the average dispensary to the average patient are much crowding, much waiting, much hurry.

These conditions have been remedied to a great extent in recent years in the better dispensaries, but they still prevail much too widely, particularly in the larger institutions. They are due chiefly to the lack of adequate administrative staffs, and the fact that the doctors are usually unsalaried and cannot afford to give sufficient time. In these respects, lack of adaptation to the needs of the foreign-born patients is merely part of a general level of inefficiency which applies to all patients. But the results of such inefficiency are usually more serious for the foreign born than for the native born.

The aim is to get results in treatment, not merely to see patients and diagnose their diseases. Success depends not only upon the doctor's skill and wisdom, but upon the patient's understanding his directions and the patient's intellectual and financial ability to carry out these directions.

The doctor's hastily spoken directions may be 80

IMMIGRANT HEALTH AND COMMUNITY

per cent understood by an American with a good common-school education. The same directions might be 50 per cent understood by an Italian workman who had picked up a knowledge of English but had never been to school. They might be less than 20 per cent understood by a Jewish or Polish woman who spoke only a few words of English, knew little of the doctor's vocabulary, and nothing of the conditions to which he referred. The medical results of treatment would necessarily differ in these three cases. As an organization aiming for efficiency in medical results, it is the dispensary's business to equalize so far as possible the patients' ability to understand instructions and to carry them out.

MEDIUMS OF COMMUNICATION

The first and most obvious effort which dispensaries have made to overcome the difficulties of dealing with the foreign born has been against the barrier of language. Signs in different languages, directing patients where to go, are an administrative convenience usually found in dispensaries. The use of leaflets on the feeding of babies, and the care and prevention of tuberculosis or venereal diseases, already referred to in connection with field work, is fairly frequent in dispensaries. Foreign-speaking doctors have been employed in not a few institutions. For interpreters, dispensaries generally have depended upon some employee or some patient called in for the occasion.

IMPORTANCE OF THE ADMISSION DESK

One of the important stations in the dispensary is in the admission hall, where the patient visiting the dis-

THE DISPENSARY

dispensary for the first time must be met, have his name, address, occupation, size of family, earnings, ascertained and recorded, and be referred to the proper clinic for diagnosis and treatment. The admission desk is a central point in dispensary administration. His treatment there largely determines the patient's emotional tone in his farther progress through the waiting rooms and the clinics, and the attitude of mind with which he receives and interprets his instructions.

Far too little emphasis has been laid by dispensaries upon the work at the admission desk. Too often it has been left to a clerk. Possibly some one has been engaged who can speak one or more of the prevalent foreign languages, but mere facility in language is not sufficient to insure tactful and wise handling of many personalities of varying races. Not infrequently nurses or internes are detailed to admission service, but for such short periods that they have no incentive to acquire special competence for the job.

One of the first needs of the dispensary, and one which has been rarely met, is the employment of skilled, permanent service at the admission desk. The employee should have received, or should be given opportunity to acquire, the special training necessary for really efficient performance of this work. Knowledge of the language, while a great convenience, is not so essential as knowledge of the backgrounds and characteristics of the people. In a dispensary an interpreter can almost always be secured in an emergency. It is impracticable to have paid interpreters sufficient to cover all the different languages found among patients in the average dispensary, but em-

IMMIGRANT HEALTH AND COMMUNITY

ployees speaking the more common languages should be found.

The conditions relating to the acquirement of foreign languages by visiting nurses and other field workers apply with equal force to social workers in a dispensary, particularly to those at the admission desk. As much knowledge of languages as is necessary to make a psychologically pleasant approach to each patient is invaluable at the admission desk, and some degree of this facility should be expected of any person regularly employed there.

SOCIAL-SERVICE DEPARTMENT

The most important step which a dispensary can take to adapt its internal administration to the needs of the immigrant is to organize a strong social-service department. The admission of new patients should be in the charge of this department; the worker or workers at the admission desk should hold permanent positions there, and be especially qualified to deal with the races and types of people who come frequently to the dispensary.

In the dispensary, as well as in the hospital, the social-service department has a double function. In the first place, it is the agent dealing with patients who are under the doctor's care, assisting the physician in controlling the patient's personality and environment, so that medical treatment can be successfully carried out. But social service is also an administrative arm of the dispensary. The social worker is of value at the admission desk and in the dispensary clinic itself, because she is trained to study

THE DISPENSARY

people and deal with them on co-operative human terms. In this respect the spirit of the social-service department tends to be a useful counterbalance to the highly specialized professional activity of the medical staff itself.¹

VALUE OF FOOD CLINIC

A food clinic is a valuable adjunct to a dispensary, since here, as in the hospital, dietary problems are a significant element in the treatment of disease. A well-trained dietitian can advise and instruct patients in the selection, purchase, and preparation of foods. She can work out family budgets and adapt a medically prescribed diet to the patient's previous food habits and the financial means available. Such a food clinic must take into account the accustomed foods of the foreign born. If this is well done the food clinic not only furthers the medical treatment of patients, but is an invaluable aid in winning their understanding and confidence.

FOREIGN-BORN PERSONNEL

The presence on dispensary staffs of foreign-born or foreign-speaking doctors is advisable, whenever it is possible to use such physicians without lowering medical standards. Many notable examples of invaluable service rendered by such physicians can be found, both in large, central dispensaries and in local clinics. Mention has been made of a certain lack of sympathy

¹ Bertha C. Lovell, "Social Worker as Clinic Executive," *Modern Hospital*, August, 1919, vol. xiii, no. 12, pp. 153-155.

IMMIGRANT HEALTH AND COMMUNITY

shown by the foreign-born visiting nurse for people of her own country. The foreign doctor in the dispensary clinic has sometimes shown the same characteristic. This is a problem of personality. To secure just any foreign-speaking doctor is not enough. He must be a competent, worth-while foreign-speaking doctor, concerned with assisting his people.

A large clinic needs a considerable administrative staff: a clinic secretary, a clerk, a nurse, a social worker—one or more of each. Where a number of people must be employed, careful planning and selection can get together a staff who, between them, have a knowledge of the languages and, what is even more important, an understanding of the backgrounds and characteristics of the immigrants chiefly encountered. Under a well-trained, wise clinic executive, a young woman of foreign parentage speaking one or more European tongues may be extremely valuable as a clerk and interpreter, her deficiencies of judgment about people and situations being balanced by her superior ability in communication. The selection and balancing of the staff of such a clinic is a problem for the superintendent or administrator, who should hold in mind both the purpose of adapting the clinic to the needs of the people and the necessity of understanding the people as a basis of such adaptation.

NEED FOR LOCALIZATION

One of the things which we have found to militate against the use of dispensaries by immigrants is distance away from the home neighborhood. To reach the people, and particularly to overcome the obstacles

THE DISPENSARY

presented by lack of education and unfamiliarity with the American environment, the dispensary must be brought to the people, and not wait for them to come to it.

This principle has been recognized by the public-health dispensaries. They have not been institutional. They have done what the advertising men call "going out after the business." The establishment of a chain of clinics or of infant-welfare stations in neighborhoods which particularly need their services, is characteristic of recent public-health endeavors.

The mere localization of a clinic, rendering the building, and at least some of the workers in it, familiar by sight to the neighborhood, and the neighborhood familiar to the workers, is a long step in adapting the institution to its clientele. The dispensary must compete with such commercial medical resources as the quack and the drug store. Localization removes one of the disadvantages under which the dispensary otherwise labors in a competition wherein the aggressive party has the advantage. If the principles of adaptation of the dispensary to the immigrant were to be listed, that of localization should have first place.

In the metropolis, or even in the city of moderate size, a local clinic or health center can serve only a small area. Therefore, there should be a number of such clinics, each with a definite district. Large dispensaries or out-patient departments, however, must be located at central points in a city, or where transportation lines furnish ready access, and in each community there cannot be very many such large dis-

IMMIGRANT HEALTH AND COMMUNITY

pensaries fully equipped with every modern resource for scientific work in medicine. How shall the large central dispensary, which necessarily draws from a wide area and cannot be familiar to many persons as a neighborhood agency, overcome the disadvantage of distance from many who need its services?

COMMUNITY PLAN FOR MEDICAL SERVICE

The answer to this question can be found only in a community plan for medical service. So long as each dispensary is planned, located, and administered as a wholly independent agency, the best adaptation of the large dispensary to the needs of special localities, and particularly of immigrant localities, presents almost insoluble problems. The local dispensaries or health centers should be interrelated both as to staff and as to administrative methods. These should refer patients needing treatment requiring the facilities of a large institution, to the central dispensaries. They will then build a bridge between the neighborhood and the big, central institution.

The important thing to remember is that the obstacles are not so much material as psychic. Experience has proved that distance alone is a slight deterrent when patients know the institution to which they are to go, and are confident of securing there a greatly needed service. It is the fear of the unfamiliar, the rumor that strange doctors will practice on them, that stand in the way.

The local dispensary, with its familiar quarters and visiting nurses, is the best means of acquainting the immigrant with the organized medical resources of his

THE DISPENSARY

new country. The success of the large central dispensaries in reaching the newer immigrants, many of whom are particularly in need of their services, must rest largely upon the existence in the community of an adequate number of local clinics or health centers, properly co-ordinated one with another and with the central medical resources.

CO-OPERATION OF IMMIGRANTS

The dispensary is in a favorable position to secure the co-operation of the immigrants themselves, their leaders and organizations. Some dispensaries build up a list of those whom they call the "grateful patients" (G. P.) or "pleased patients," indexed by locality, nationality, language, and in various other ways, so that they can be called on at need for friendly service, as interpreters or to persuade patients to carry out medical treatment. Here again the social-service department should be the agent of the dispensary in making this idea effective. The local clinic or health center finds it comparatively easy to build up co-operation with neighbors or neighborhood organizations. Here, as elsewhere, the prerequisite is the right point of view on the part of the superintendent and managers of the dispensary, a point of view based on knowledge of the backgrounds and characteristics of the people with whom the dispensary deals, and filled with sympathy alike for their qualities, their deficiencies, their needs, and their achievements.

XVI

INDUSTRIAL HEALTH WORK

WHILE most manufacturers are probably conscious that they employ numbers of immigrants, a few figures may emphasize the importance of giving special consideration to this group in industry. In 1908-09 the United States Immigration Commission made an investigation of immigrants in industries, which was summarized by Jenks and Lauck.¹

The proportions of foreign born among the operating forces of the principal branches of manufacturing and mining were as follows:

More than half of the iron and steel workers,
employees of oil refineries,
slaughtering and meat-packing establishments,
furniture factories,
leather tanneries and finishing establishments,
woolen and worsted goods, and
cotton-mill operatives;
about two fifths of the glass workers;
one third of the silk-mill operatives,
glove-factory employees, and
cigar and tobacco makers;
seven tenths of men and women garment makers;
more than one fourth of the boot- and shoe-factory
operatives;
four fifths of the wage earners in sugar refineries.

¹ Jenks and Lauck, *The Immigration Problem* (1913 edition), pp. 148-149.

INDUSTRIAL HEALTH WORK

Does the immigrant employee, because of his foreign birth, present special medical, sanitary, and health problems to the industrial physician? If so, what methods of solving these problems are being tried out, and with what success? What should be the interrelation of industrial medicine and the general medical service of the community?

As in other branches of this study, information was secured partly by questionnaires and partly by personal visits and interviews. Health conditions and problems vary with the location of an industry, with its character, and with the racial elements of its employees. Consequently, manufacturing establishments in large cities and in small towns, mining communities in several parts of the United States, and finally some mercantile establishments, were visited. The Atlantic coast states, the regions around Cleveland and Chicago, parts of Pennsylvania, Minnesota, Michigan, Colorado, and California, were included. About fifty different establishments were visited, five or six people usually being interviewed at each. The industrial physicians, the nurses, the safety and sanitation departments, and the employment managers, were the persons sought for.

To get the industrial physician's own conception of what problems the immigrant brings to him, the questionnaire method was first used. We find in the replies expressions of every point of view, from the big-stick theory up. One doctor writes:

There is an endless field for doing good, and we are desirous of doing our part, especially teaching these men of foreign birth to respect and honor their adopted country. Teach them how to live in their homes, and

IMMIGRANT HEALTH AND COMMUNITY

make them desirable citizens, proud to live [in the United States].

A contrast to this paternalistic approach is the following:

Give them a square deal, house them in habitations fit for humans rather than in hovels and rabbit warrens, appeal to them by means of pictures, talks in their own language, and an honest desire to help them, rather than, as has been done, work them to death, pay as poor a wage as possible to compel them to accept. . . . This is my idea of . . . what might be done to make them better physically, mentally. We must meet them on the level, and not condescend from a superior height.

The doctor who would force the immigrant to conform to our standards is well represented in the questionnaires. One physician suggests that we "eliminate as far as possible all foreign institutions," in the same breath that he advises the "abolition of the saloon." Another doctor feels the great need for "education of the employer" if these problems are to be solved. He is seconded by one who writes that both "employer and employee must be educated, the former to spend money for a first-class (welfare) organization, and the other to accept graciously that which makes him or her a more valuable worker."

The following anecdote illustrates better than anything else an all too prevalent attitude toward the immigrant employee.

While I was talking with one of the nurses a Hungarian, small and dirty, violently gesticulating and speaking broken English, came bursting into the room next ours. The employment manager stepped in from the next room to try to quell the disturbance. When I passed through, the nurses and the employment manager were standing in

INDUSTRIAL HEALTH WORK

great annoyance, laughing at this little man. He was so frantically eager to make them understand his trouble that he was weeping at his inability to do so, while they merely grinned at him. The employment manager explained the trouble:

"Oh, that man's wife is sick and he wants us to pay the meat bill." Then he laughed. How many facts lay behind that statement it is hard to say, nor was any sincere attempt made to find out from the man the specific cause of his distress. He went out, returning in a few moments, still shaken by his excitement, to find the door ordered locked against his re-entry.

The industrial physician needs more than medical knowledge to deal with the problems presented by the immigrants in industry. It is difficult for him to feel anything but exasperation at the personal uncleanliness of an immigrant employee. Does he, however, know what the race habits of this people were with regard to bathing, or what bathing facilities this particular man now has in his American home? To accomplish the best results in preventing accidents, curing disease, and promoting health and efficiency among foreign-born employees requires both a consciousness of immigrant backgrounds and a knowledge of the conditions under which immigrants live in this country.

The ideal attitude of industry toward this question appears in the following quotation:¹ "The manager of the future . . . will love men, and will work with them to make them better men. He will study men, for in the last analysis men are, and always will be, the foundation of industry and civilization. . . ."

¹ Charles E. Knoeppel, "Industrial Organization as It Affects Executives and Workers." Address before the American Society of Mechanical Engineers, New York City, December, 1918.

IMMIGRANT HEALTH AND COMMUNITY

The industrial physicians were asked to mention the outstanding problems in connection with their work with immigrants. The answers are indicated below:

TABLE XXXII

OUTSTANDING PROBLEMS OF THE FOREIGN BORN IN INDUSTRY
MENTIONED BY SEVENTY INDUSTRIAL PHYSICIANS

PROBLEMS	TIMES MENTIONED
Housing conditions.....	22
Kinds and preparation of food.....	12
Personal hygiene.....	10
Tuberculosis.....	7
Alcohol.....	6
Occupational diseases (chiefly lead poisoning)...	6
Teaching English language.....	6
Trachoma.....	4
Bad teeth.....	3
Extension of medical service to homes.....	3
Venereal disease.....	2
Hernia.....	2

It is evident that many of the "problems" mentioned in the questionnaires are common to all employees of industry, native and foreign born. But as we have seen, the immigrants' problem is complicated by unfamiliarity with language and American conditions, and by habits of life derived from an entirely different environment.

The problems listed above group themselves roughly into two classes, those that can be taken care of within the factory walls, and those that extend industrial medical work into the homes of the employees and the community. The former includes medical examination, emergency work, care of occupational as well as general diseases, personal hygiene as well as plant sanitation. The broader problems of housing,

INDUSTRIAL HEALTH WORK

family care, and public-health work in the community fall in the second group and represent an extension of industrial health work already undertaken in many places.

MEDICAL SERVICE IN INDUSTRIAL ESTABLISHMENTS

Most industrial clinics originated as a result of accident compensation laws. In the first stage of development a first-aid kit was kept in the building and doctors were engaged to answer emergency calls. The next step was the installation of first-aid stations within the plant itself, with a nurse employed full time; a surgeon was still on call for serious accidents. Selby, in his study of 181 plants with clinics,¹ found that 14 per cent had what he called "detached emergency service"—that is, doctors were summoned only in case of accident. Then began the physical examination of applicants for work, and the periodic re-examination of those exposed to industrial health hazards. From this it was not a far step to the full-time employment of physicians as well as nurses. Selby found that 65 per cent of the 362 doctors in the plants he visited were full-time men.

Following this, the scope of the work has broadened. Medical staffs have been enlarged to include oculists and dentists. Special medical equipment is often provided. Service is extended to the homes. Educational literature and health talks are part of the activities of a few departments. Everywhere there is evidence of the emphasis put on preventive medicine. This expansion of industrial medical work is ably

¹ C. D. Selby, *Studies of the Medical and Surgical Care of Industrial Workers*, United States Department of Labor, 1918.

IMMIGRANT HEALTH AND COMMUNITY

brought out by Dr. Harry E. Mock, in the *Journal of Industrial Hygiene* for May, 1919.

In this field, what recognition has there been of the special problems of the immigrant employee, and what has been done to meet them? The best way to discover this is to follow an individual immigrant through a typical industrial clinic. His first point of contact is the man at the desk in the employment office. If our applicant understands any English he will get by there somehow. If not, some friend or neighbor may help out, or he will have to talk as best he can by signs. In one particular factory, which we are taking as our example, he is then sent to the clinic for physical examination before being placed at a job. Here his troubles increase. He is stripped, without knowing why in many cases, because he can't understand what is being said. Then the doctor makes his examination.

How can an English-speaking physician hope to get a personal history from an immigrant who understands at best only a little English, and speaks imperfectly? How can the doctor explain to such a man the necessity of remedying his physical defects so that he may become a more efficient workman for the company which is going to employ him? If the employee knows a little English he may catch the words "operation," "cut," or "hospital," and at once terror may fill his soul.

The new employee's job may expose him to the hazards of industrial disease. Poisons, protection from which requires careful personal habits and cleanliness, are a greater hazard to such a workman than to the native born. The situation must be carefully explained. Here again the barrier of language is a handicap. To make clear the danger of something the

INDUSTRIAL HEALTH WORK

workman cannot see, such as wood-alcohol vapors, is difficult if he cannot understand the language of the instructor.

An interpreter who is familiar with medical and social work, and who also understands the racial heritage of the man concerned, is needed. To work through a third person is clumsy at best; but it is infinitely better to use a trained interpreter than any untrained person who happens along.

It is not unlikely that the man we have been following through a clinic is very dirty. The doctor's first and peremptory orders are to take a bath—not once, but frequently. Then he cannot understand why his orders are not carried out. The suggestion of frequent bathing is not such a great shock to a native American. He at least knows our bathing customs and is familiar with city water supplies and bathtubs. But to the newly arrived immigrant such a suggestion may indicate lunacy or evil intent. Roberts¹ has cited some vivid examples, of which the following is one, of the attitude some immigrants have toward frequent bathing:

A young Pole was induced to go into the swimming pool in a Young Men's Christian Association; after that he kept away from the building, and the secretary went to find out why he stayed away. The mother of the lad met him, gave him a piece of her mind, that he dared make her boy take a bath in winter time. "Did you want to kill him?" Thousands of immigrants from southeastern Europe do not appreciate the value of personal cleanliness.

One important way in which the industrial physician can aid his employer to reduce disease and accident, is

¹ Peter Roberts, *The New Immigration*, 1914, p. 134.

IMMIGRANT HEALTH AND COMMUNITY

to enter the mother tongue and nationality of every man examined on his medical records, and then analyze statistics by race. The making of the original entry may be the duty of the employment department, but the medical department should know and utilize the facts.

So few industrial clinics do this that the point cannot be too strongly stressed. Our investigation revealed that many nurses had no knowledge of the races in their plant, the number of employees of each, nor of diseases or accidents by races. They did not even know that there was a place on their medical record for a nationality entry.

A few doctors have carried out this idea with great advantage, not only to the company employing them, but to others having to meet the same problems. One of these men found by analyzing his records that hernia occurred more commonly among the southeastern European employees, Italians in particular, than among other races doing the same kind of work. His next step in regard to this observation will probably be a study of food habits among the Italian employees. This same doctor has noted more pernicious anæmia among Swedes than among the southern European races. So he will go on analyzing the data secured day by day in the routine work of the clinic, and applying the knowledge gained to the practical demands of his industry. There is a great need for more extended study of this kind to provide a sound statistical basis for work with foreign-born employees.

ACCIDENT PREVENTION

Education of employees to prevent accidents and industrial diseases has received a great deal of attention

INDUSTRIAL HEALTH WORK

since workmen's compensation laws began to be enacted nine years ago. The National Safety Council is an outgrowth of this movement. Yet far too little importance has been attached to the human element in industrial accidents, the mechanical elements receiving first attention. In recent years, however, safety engineers and plant managers have recognized the human factors much more fully than formerly, and the foreign-born employee is beginning to receive attention.

Safety department heads usually speak as if all workmen had a common background of habits and tradition on which to base educational work for accident prevention, and as if all could read and write the English language. On the contrary, the foreign-born employee is not infrequently a special accident hazard, to himself, his fellow workers, and his employer.

The great majority of the recent immigrants have come from the peasantry of Europe and know nothing of industrial conditions and demands. Of 181,330 male employees from whom information was secured by the United States Immigration Commission, only 15.3 per cent had been employed in manufacturing before coming to the United States; 10.3 per cent had been general laborers; and 53.9 per cent had been farmers or farm laborers.¹ These facts, combined with the fact that it is several years before the immigrant learns to speak English, make him a special accident problem.

The more progressive among employers to-day recognize this factor. According to the Semet-Solvay

¹ Jenks and Lauck, *The Immigration Problem*, fourth edition, 1913, p. 493.

IMMIGRANT HEALTH AND COMMUNITY

Company of Detroit,¹ "there are thousands paid out for injuries, many of which may be traced directly to the inability of the employee to understand English." Clarence H. Howard, president of the Commonwealth Steel Company, St. Louis, says:² "Records kept in our industry show that 80 per cent of the injuries received by our workmen were among the non-English-speaking employees, though they constitute only 34 per cent of the force." Henry Ford's testimony is that³ "accidents in the plant have been decreased 54 per cent as employees are able to read factory notices and understand instructions."

There are other ways besides teaching English to reach the immigrant employee in accident-prevention work. The usual method of breaking in a new workman to a hazardous job is to turn him over to the mercies of a busy foreman, who is pretty sure to speak English only, though he may know a few foreign phrases. This man is generally regarded by the manager as *ne plus ultra* at this work, and to him is most often intrusted the training of the worker ignorant of American machinery, of health hazards in industry, and of the very language in which his instruction is given. The "dumb" and confused immigrant will nod his head, indicating that he understands what really has been Greek to him. Such methods as these result in large accident rates and perhaps numerous cases of industrial disease in places where immigrants are employed.

The shop organization should make provision for

¹ *What Industrial Leaders Say About Americanization*. Leaflet of the Chamber of Commerce of the United States of America, 1918, pp. 8, 10.

² *Ibid.*

³ *Ibid.*

INDUSTRIAL HEALTH WORK

explaining the hazards of his job to the non-English-speaking workman in his own tongue. Foreign employees who have been through the breaking-in process might well be placed on a shop committee to handle this matter, under the direction of a central "safety department." The haphazard methods of the past must give way to an intelligently planned and organized system for instructing the immigrant employee.

One concern claims to have developed a method of using their foremen in this connection with satisfactory results.¹

An interesting innovation is in operation at the Amoskeag Manufacturing Company plant to reduce accidents at especially hazardous work. The overseer or foreman is required to fill in, sign, and file with the employment department a certificate stating that he personally provided a suitable and safe place in which to work, inspected the machinery and apparatus to be used, and found them safe and suitable for the work in hand, explained the company's rules and regulations for employees engaged in such work, gave express orders never to clean gears, belts, or moving parts of machines while in motion, and acquainted the fellow workman selected to teach the new employee with the latter's inexperience, and instructed him to point out the dangers incident to such work. Special care is taken to give such instruction in the new employee's own language—if necessary through an interpreter, whose name must be given.

Posters and leaflets in foreign languages will be of service when the employee is literate in his own tongue. It must not be forgotten, however, that of the immigrants from southeastern Europe fourteen years of

¹ *Bulletin No. 3*, Chamber of Commerce of the United States of America, June 1, 1916, p. 2.

IMMIGRANT HEALTH AND COMMUNITY

age and over, admitted to the United States from 1897 to 1917, 33 per cent were illiterate, and to them rules and regulations printed in their mother tongue will do no good.

The Pennsylvania Railroad has "an elaborate system of pamphlets for first-aid work and instruction in English. The lessons in the latter group are extremely practical, utilizing the mechanical tasks of the worker as subject matter. English and the foreign language are given in parallel columns, with illustrations showing proper and improper methods of work from the point of view of the safety of the employee."¹ Other large firms may well study these methods. This same railroad has prepared a film "called 'The Americanization of Tony,' which introduces 'Safety First,' and emphasizes the need of Americanization."² The possibilities of the moving picture in this work are great, and as yet but little developed.

Methods used for the promotion of safety work apply equally well to plant sanitation. The educational value of clean, modern toilet facilities, in a factory, cannot be overestimated, but the immigrant must be taught how to use them. Many immigrants have never in their lives seen a water-flushed toilet before coming to this country.

Any campaign, then, for the prevention of accidents and industrial diseases and the promotion of safety and sanitation, must take into consideration the foreign-born employee. His background differs widely

¹ *What Industrial Leaders Say About Americanization*. Leaflet of the Chamber of Commerce of the United States of America, 1918, p. 9.

² *Bulletin No. 23X*, Chamber of Commerce of the United States of America, June 1, 1918, p. 3.

INDUSTRIAL HEALTH WORK

from that of the native American workman; his ignorance of the English language makes it impossible for him to understand the educational material which reaches the native. Special methods must be employed in order to achieve the best results.

BENEFITS AND CO-OPERATIVE PLANS

A number of schemes for insuring employees against accident and sickness are operating in concerns having many foreign-born employees. Notable is that of the International Harvester Companies, whose Employees' Benefit Association dates from 1908. Over 50 per cent of the employees are said to be of foreign birth. Sick benefits, disablement benefits, and death benefits are provided, from a fund made up of contributions from members of about 1.5 per cent of their wages, and contributions from the companies. The board of trustees is chosen half by employees and half by the companies. Medical care is not furnished. The average membership from the manufacturing plants during 1917 was 78.4 per cent, and included large numbers of foreign-born employees.

Even this plan, certainly one of the most successful of its kind, does not assure competent medical service at reasonable rates. The employee receives as sick benefit half his usual weekly wage, and is required to take care of himself "and have proper treatment." How to pay for doctors' fees and medicines in addition to the regular living expenses of the family, on half the usual income, must be a hard nut to crack. Plans of this type are a definite help to many families, but do not solve the problem of providing adequate medical

IMMIGRANT HEALTH AND COMMUNITY

care. Most of them involve much less participation by the employees than does the one described above.

There are also plans for industrial medical service initiated and controlled entirely by the workers. The Joint Board of Sanitary Control, in New York City, furnishes perhaps the most prominent example. This is an organization managed and supported by workers in certain women's garment trades, and touching the lives of over 75,000 workers in more than 2,700 industrial establishments. Through its members the board supervises conditions of safety, sanitation, and general conditions relating to health in the clothing industries of New York, which are united under the Protocol of Peace. It seeks to enforce "standards not by police power or compulsion, but by education, co-operation, and educational persuasion."¹

In 1912 it established a clinic where any worker in the industry may be examined, and which supervises the sick benefits paid by the locals of the union. The unions also pay for sanatorium treatment for members suffering from tuberculosis, and provide nose, throat, eye and ear, and dental clinics. "The main significance of these clinics lies, of course, in the fact that they are conducted, financed, and managed by the workers themselves, for their own benefit."¹ As large numbers of the garment workers are Jews and Italians, either foreign born or the first generation here, it is evident that their organization is closely related to the problem of medical care for the immigrant. Only a minority of the members, however, appear to make regular use of their clinics.

¹ Dr. George M. Price, *Modern Medicine*, May, 1919, p. 49.

² *Ibid.*, p. 50.

INDUSTRIAL HEALTH WORK

Another phase of industrial medicine with which the industrial physician should be familiar is to be found in New York City.¹ This is the relationship established by the Department of Health between its Division of Industrial Hygiene and the labor unions in the city, and known as the Labor Sanitation Conference. It is an endeavor to associate labor unions and a city department in improving general health conditions in the factories of the city. Education, both of employees and employers, is a prominent part of the work. The police power of the city department is used when need arises, and the 75,000 members of the affiliated unions act as voluntary inspectors for the department. On one occasion the department conducted physical examinations on a voluntary basis for union members, who were largely foreign born.

To be successful, such plans require the voluntary co-operation of all workers concerned, and this involves an immense amount of educational work with the immigrants. Most of the foreign born are not so much interested in health as they are in personal illness. Sickness makes them think of the health they have had, but so long as they are well it is very difficult for them to appreciate the need of preventive work, and that is the ultimate interest of such organizations as these in New York City.

It should be apparent that plans for co-operative medical service by and for employees will not supersede the well-developed clinic in an industry. Many medical and sanitary problems are closely linked with the individual factory and can best be dealt with from

¹ Dr. Louis I. Harris, *Monthly Bulletin of the Department of Health of New York City*, June, 1917.

IMMIGRANT HEALTH AND COMMUNITY

the inside. The factory clinic should maintain supervision of the immigrant's health and the conditions under which he works. It should see directly or indirectly that medical care for himself and his family is available and within reach of his pocketbook. Whatever tends to keep workers well tends also to stabilize labor conditions. Good medical service to employees is also service to the employer.

EXTENSION OF SERVICE TO HOMES

A few industrial physicians have extended medical service beyond the plant itself to the homes of the employees. The value of such service to the immigrant and his family is great, especially if obstetrical care and medicines are included.

Not all physicians, however, agree to the advisability of doing this. It is contrary to the policies of such representative plants as the Norton Company in Worcester and the Goodrich Company in Akron, Ohio. Both these plants are located in cities large enough to provide other medical facilities, and their doctors feel that the industrial physician should not infringe on the practice of private doctors.

Endicott Johnson and Company, of Endicott, New York, hold the opposite point of view. They have three nurses for visiting the homes of their employees and another three for clinic activities. Obstetrical service, as well as eye, ear, nose, and throat work, are free to the families of employees. Their visiting nurses make both prenatal and postpartum calls.

Apparently a company's attitude on this question is determined to a large degree by the size of the

INDUSTRIAL HEALTH WORK

community in which it is located, and by the other medical resources which are available in the vicinity. The boundary line of responsibility is a delicate and changing one, and its decision for any industrial establishment requires careful analysis of environment.

In most places where the physicians employed by industries are the only ones available, it is of utmost importance to the immigrant employee that his family have access to the doctor's services. Moderate prices mean more prompt medical care, and this in turn means reduction in time lost through illness of the worker or his family.

Nursing aid extended to the homes has great value in any locality, particularly in relation to the immigrant. The visiting nurse is probably more welcome than any other person in the homes of the foreign born, because she comes on errands of mercy and helpfulness.

This is one reason why it is disastrous for an industry to use a nurse as a truant officer in following up absences among the immigrant workers. They soon feel that she to whom they have turned as a friend in time of illness has become a spy and intruder in their family life. The consequent resentment kills the nurse's opportunity to carry on educational work in connection with her friendly aid.

Hers is the chance to adjust food habits to the demands of American life; to teach American standards of hygiene and sanitation in both factory and home, and to spread knowledge as to the proper care of the children who are to be the workmen of to-morrow. Only by slowly winning the immigrant's confidence and trust can extension of medical service be made

IMMIGRANT HEALTH AND COMMUNITY

of value to him and to the industry which employs him.

HOUSING

Some industries have extended their health work into the field of housing. The necessity for this, also, varies largely with the circumstances in which the industry finds itself. That the housing of his workers is important to the employer needs little proof. Evidence from England on this point is brought by Charles C. May in *Modern Medicine*:¹

Given two factories with identical conditions in all other respects, but one housing its workers well, the other permitting the old-style "settlement" to exist . . . it needs no argument to prove which of the two factories will have the greater charge for labor turnover. . . .

TABLE XXXIII

COMPARISON OF THE WEIGHT AND HEIGHT OF CHILDREN OF DIFFERENT AGES, LIVING IN BOURNEVILLE AND BIRMINGHAM, ENGLAND

	Age			
	6 Years	8 Years	10 Years	12 Years
<i>Weight in Pounds</i>				
Boys, Bourneville.....	45.0	52.9	61.6	71.8
“ St. Bartholomew’s Ward.....	39.0	47.8	56.1	63.2
Girls, Bourneville.....	43.5	50.3	62.1	74.7
“ St. Bartholomew’s Ward.....	39.4	45.6	53.9	65.7
<i>Height in Inches</i>				
Boys, Bourneville.....	44.1	48.3	51.9	54.8
“ St. Bartholomew’s Ward.....	41.9	46.2	49.6	52.3
Girls, Bourneville.....	44.2	48.6	52.1	56.0
“ St. Bartholomew’s Ward.....	41.7	44.8	48.1	53.1

¹ Charles C. May, "Better Housing," *Modern Medicine*, May, 1919, p. 70.

INDUSTRIAL HEALTH WORK

Persuasive are the statistics . . . of the effect on boys and girls, in weight and height, of the conditions of a garden town like Bourneville, as compared with Saint Bartholomew's Ward, in Birmingham, only twenty minutes away

Take these two groups of boys and girls, one hundred from the city slums, the other hundred from the garden town, and line them up before your industrial magnate. "There you are, sir. From which group will you recruit your shop forces?" Is there a question as to where his choice will light?

The Goodyear Tire and Rubber Company issued in 1918 a booklet describing their building projects, entitled, "Which Shall It Be, Home or Hovel?" According to this circular, building of houses for employees "is not charity. It is not graft. It is humanity; above all, good business. No man worried at home, living in a hovel surrounded by dirt and filth, his family subjected to all the dangers and disease which infest such habitations, can do good work."

Sometimes houses erected by an industry are only rented to its employees; sometimes they are sold to workmen on the installment plan. More and more industries are buying land in rural regions and building their own villages near by. Such houses built to-day are equipped with modern conveniences; made to meet the needs of various sized families, including those which take boarders; and often provide space for the little garden so dear to the heart of the immigrant fresh from the fields of Europe. The importance of this last point is appreciated by one large company which is now considering building for its employees.¹

¹ Notes by H. T. Waller, Goodrich Company, sent to W. M. Leiserson, of the Americanization Study staff.

IMMIGRANT HEALTH AND COMMUNITY

. . . From our experience we do, however, urge that any plan of housing for the immigrant employee should include a lot of land enabling the foreign employee to exercise his native ability in market gardening.

Homes built in this way will be powerful factors in promoting health and in teaching the immigrant American standards of sanitation. Many of the employers, who will only rent their houses to employees, say that this policy is necessary to protect the property and to maintain a good standard of cleanliness. Peasants who have been accustomed to the most primitive housing, without running water or toilet facilities, who have frequently lived in the same building with their animals, cannot be expected at once to accept or to practice American methods of keeping clean.

A few industries are doing educational work through women inspectors, whose business it is to inspire the immigrant with the desire to imitate American standards. These women work in the homes, and in one case they also utilize a neighborhood center established and supported by the industry itself. A very good example of such a combined housing and educational policy is to be found in Morgan Park, Minnesota.

The question of boarders seriously affects the housing of foreign-born employees. Boarders and roomers are usually taken for one of two reasons—economic necessity, or the desire to help newly arrived compatriots. Industry has the power, in a large degree, to abolish the first factor. The seriousness of the second varies according to the races employed. The groups which average the greatest number of boarders or roomers are those among whom there is a large

INDUSTRIAL HEALTH WORK

proportion of single men, chiefly the Croatians, Lithuanians, Magyars, Poles, Serbians, Rumanians, and Greeks. In considering any housing project for industrial workers the races involved should be studied in order to adapt the plans as far as possible to their particular habits and needs.

FLOATING LABOR CAMPS

Quite different from the problem of housing factory employees is that of accommodating floating labor in camps. This type of labor is usually associated with such industries as lumbering, ice cutting, beet-sugar and fruit growing, or with highway and railroad construction and repair work, and is largely composed of immigrants, as is brought out by Jenks and Lauck.¹

Disregarding geographical lines, it may be said, in general, that foreign-born wage earners constitute more than three fourths of the entire number of persons engaged in railway and other construction work.

In 1912 and 1913 W. M. Leiserson made a study of labor camps in Wisconsin for the Industrial Commission of that state.² Of the 50,000 wage earners living in camps in Wisconsin, he calculated that 20,000 were housed in bunk cars for railroad work; 20,000 in lumber camps; 5,000 in ice-cutters' camps, and 5,000 in camps for the construction of dams, buildings, roads, and bridges.

The railroad "gangs" were housed in box cars, which allowed 170 cubic feet of air per man, one half

¹ Jenks and Lauck, *The Immigration Problem*, 1913, p. 180.

² W. M. Leiserson, *Labor Camps in Wisconsin*, Industrial Commission of Wisconsin, pamphlet, 1913.

IMMIGRANT HEALTH AND COMMUNITY

of the legal requirement in Wisconsin. The sanitary conditions of the camps were primitive, and there was no provision for taking care of the sick. Leiserson rarely found sick men in the camps because they leave as soon as they become ill.

The housing conditions in the lumber camps were generally worse than in the railroad camps. Two of the camps were found to be better than the rest. Running water, good beds, and bedding were provided; there was plenty of space allowed per man; the buildings were light, airy, and clean. These camps had no difficulty in holding men, and were, in fact, turning away applicants.

Another example of suitable housing is that of the Park Falls Lumber Company of Wisconsin.¹

Each logging camp has twelve cars, of which four are used for the horses. One is a power car which provides the electric current for all cars and pumps the drinking water into an air tank, which furnishes running water in the washing car and kitchen car. A vapor-heating system is used and the cars are comfortable in the coldest weather. Sleeping cars are divided into four rooms, each 12'x15'. Each room has a door and window, constructed opposite each other, to provide proper ventilation, and contains six single-spring bunks. A dining car, containing small tables, seats 114 men. An equal number of cars are placed opposite each other, with a platform in the center which is lighted at night, so that the men may pass from car to car without touching the ground. Camp and commissary refuse is removed every morning.

The company found that the original cost of such equipment was double the cost of a set of ground camps to accommodate the same number of men and horses, but states

¹ *Bulletin No. 2*, May 5, 1916, Chamber of Commerce of the United States of America, p. 8.

INDUSTRIAL HEALTH WORK

that it has brought ample return on the investment, as the camp can be moved from place to place and considerable time is saved walking to and from work, while the men appreciate these conditions so much that the company has had no trouble in retaining them since operations were commenced. It is now planned to add a sixty-foot car to each camp fitted up as a reading room and a bathroom, and to replace all the company's ground camps with this type of living quarters.

The Commission of Immigration and Housing of California has developed standards for labor camps which may serve in many respects as models for the country. The problem in California is peculiar because of the climate and the characteristics of the Mexicans, who are a predominant element in the agricultural sections of the state. The Mexican laborer generally has his family with him, and they move as a unit from one place to another. For these workers the commission has provided small family houses and supervision of sanitary regulations. It has been equally successful in its work in the mining and lumber regions, where the labor-camp problems are similar to those elsewhere in the United States.

The wide support which the California commission has received from both employing and labor interests, its nonpolitical character, and its expert work in the field of sanitation and housing, render its findings of the first importance to the problems of the foreign born.

It is almost impossible to deal with the problem of floating labor by local regulation. The labor is too migratory; the camp is often temporary, and usually isolated. The state as a whole must set standards and supervise their enforcement. In some occupations, particularly railroad work, where the problem

IMMIGRANT HEALTH AND COMMUNITY

is an interstate one, the United States Public Health Service, or some other Federal agency, may properly intervene to prevent unsanitary camp conditions.

THE PIONEER MINING COMMUNITY

As in the floating labor camps, conditions in isolated mining communities require the employers to carry health work beyond the confines of the industry itself. This is exemplified in the Mesabi and Vermilion iron ranges of Minnesota and the copper range of northern Michigan. Seven mining towns in these two ranges were visited in the course of this study and many interviews were held with persons engaged in and affected by health work—doctors, nurses, employees, and superintendents.

When this region was first opened, housing, water supply, sewage, garbage, and ash removal, maintenance of streets, all were provided by the companies. In the iron ranges where open-pit mining obtains, permanent dwellings are impracticable. Little shacks, uninviting, unhealthful, and desolate, are erected at the edge of the pits. The company is unwilling to spend money on buildings in a locality which in a brief interval will be evacuated for another site, and the workers cannot afford to. Under such conditions less headway has been made in the solution of medical and sanitary problems than in the copper ranges.

The mines' mouths in the copper ranges are fixed for years, and here the companies provide better houses and more adequate sanitation. Overcrowding is evident, however, and public-health problems are still far from being solved.

The reason for this can perhaps be found in the so-

INDUSTRIAL HEALTH WORK

TEMPORARY SHANTIES MAY BE THE ONLY HOMES FOR IMMIGRANTS IN MINING COMMUNITIES

called contract system of industrial medicine, used widely on all these ranges. This is said to have been imported with the Cornishmen in the early days of copper mining in Michigan, when it was claimed that only assured incomes would keep doctors in the newly opened mining regions. According to the present system an amount ranging from 75 cents to \$1.50 per month, deducted from each employee's wages, guarantees the doctor an annual income in return for caring for all the medical work of the community. Given a doctor of vision and energy, the system affords possibilities for broad development of constructive health work. But too often it lends itself to exploitation from both sides; the workers make excessive demands

IMMIGRANT HEALTH AND COMMUNITY

for free medicine and medical service, and the doctor is often lax and careless.

The workers have no choice in the deduction from their wages for medical work. They have no control over the system, no voice in the administration of the funds or the choice of the doctor. Few of the contract doctors regard themselves as employees of the workers. They are engaged and discharged by the company, though paid for by the workers. Representatives of the mining companies generally seem to regard the system as "welfare work." This is also the point of view of most of the "contract surgeons." Many of the miners are indifferent to the question. Others see in it a just cause of discontent and criticism. There is evidence that the essential justice and efficiency of the system is being questioned. Everywhere symptoms of unrest are showing themselves, and the value of the system is being challenged on all sides.

In contrast to the system in these mining districts is that prevailing in Ohio and Illinois. Here, according to the Insurance Commissions of these two states, the contract system is found much less frequently, and although the general community health work is of lower grade, a serious source of unrest among the workers is absent.

In a Pennsylvania town in the Monongahela Valley, a plan has been worked out whereby industrial and community medical service is provided and administered jointly by the miners through their unions, and the company. Here membership in the health program was voluntary and responsibility and control were shared by all concerned. Surely this partnership contains the germs of a system that will work for

INDUSTRIAL HEALTH WORK

better health, as well as better feeling and understanding between the industry and its workers.

A joint plan for health which has had more extensive application is that of the Colorado Fuel and Iron Company of Pueblo. The workers as well as the management are represented on committees on safety and accidents, and on sanitation, health, and housing.¹ Jurisdiction over all matters of health and sanitation is in the hands of these committees, and these problems have been dealt with entirely by this form of organization.

The testimony of persons immediately concerned points to the success of the plan. Interest is stimulated on the part of the workers, and opportunities for self-expression and responsibility are developed. Considering the large numbers of foreign born engaged in the mining industry, the importance to health work of a plan which engages their co-operation and interest cannot be overestimated. In this way, as in no other so successfully, can American health methods and standards be adapted to the varying demands made upon them.

SUMMARY

Industrial medicine is not only a matter of health technique; it is an industrial issue. In the economic difficulties that grew up in Colorado in 1913 and 1914 medical service was distinctly an issue. To-day, in many factories and mines, an ill-understood and unexplained system of medical examination or medical care is a factor in industrial unrest.

¹ Industrial Representation Plan, Colorado Fuel and Iron Company.

IMMIGRANT HEALTH AND COMMUNITY

The foreign born constitute a large proportion of the employees in many industries; in fact, they form a majority of the entire population in many industrial communities, both large and small. Yet correspondence and conference with industrial physicians, employment managers, and others make it clear that relatively little attention has been given to the special medical and health problems presented by this important labor element.

The value of medical service to industry in securing the maximum efficiency of labor is too well established to need discussion here. In the many communities where an industry is the only large and effective force, its responsibility in this respect looms large. Moreover, the industry has a much greater hold on its employees than the visiting nurse or dispensary social worker can usually acquire, and a consequently greater opportunity to get results in curative and preventive medicine. Whatever the industry's responsibilities and opportunities in regard to labor in general, these are intensified in the case of the immigrant by his comparative ignorance and helplessness in his new environment.

Some of the major questions with which industrial physicians and nurses are dealing, are: the prevention of accidents; the prevention and, where necessary, the treatment of occupational and other diseases; the maintenance and promotion of sanitation within the plant; and of personal hygiene among the workers.

Industrial medicine must justify itself on a business basis, and to achieve profitable results it must fulfill certain requirements. It must specialize in human as well as in medical relations. Knowledge and consid-

INDUSTRIAL HEALTH WORK

eration of immigrant backgrounds are essential to overcoming the barriers of language and point of view. The method of approach to the employee should be democratic, not paternalistic, and every effort should be made to enlist him in the support and the administration of industrial medicine.

One kind of industrial medicine that will never pay is the cheap kind. Good physicians require adequate salaries. It is the cheap men who conceive of and treat people cheaply. The keen, well-trained doctor appreciates the vital importance of the human factor in medical and business efficiency, and will perceive and strive to deal with the special problems of the immigrant employee.

The industrial physician should be directly responsible to one of the high officials of his plant, as the head of any major department would be. Only in that way will the full value and importance of the medical work be realized.

The larger problem of industrial medicine hinges upon the question of its place in community health work. How far should it go beyond the walls of the plant itself? Not a few industries have undertaken housing for employees, partly for sanitary, partly for other reasons. Medical care has been extended to employees in their homes and sometimes to their families as well, in many mining communities, and in some factories and labor camps.

The contract system, as developed in the iron and copper ranges of Minnesota and Michigan, is in the main a creature of the employer rather than of the community, and has the essential limitations of the manner of its creation. It is apparent that in a newly

IMMIGRANT HEALTH AND COMMUNITY

opened country the contract system will assure the employees and their families medical services which would be beyond their reach if the industry did not come forward. But almost everywhere it is in use it shows the evils of any scheme of medicine which is on a commercial basis, but which has not developed with the understanding and co-operation of those who are to receive its care.

The entrance of industry into community medical care has been frequently observed to coincide with a low level of public-health work in the same area. This is particularly true in regions where the community consists largely of foreign-born employees too recently immigrated to take much part in normal community activities.

A marked contrast could be drawn between the conditions described on the iron and copper ranges in northern Minnesota and Michigan, where practically all the medical and health work is done by the industry for the community, and the situation in Akron, Ohio. Several large industries in Akron have their own well-developed departments of industrial medicine; they have also bent their efforts to a notable degree to advance and assist the health work of the community under the city government. Where industry has a farsighted view instead of a short-range commercial one, it will encourage community health work and not substitute industrial medicine for it.

On the whole, except temporarily under pioneer conditions, the development of industrial medical service outside the industrial establishment itself must be regarded as an influence against Americanization in the larger sense, and against the more permanent

INDUSTRIAL HEALTH WORK

interests of the communities' medical and health work. If the administration of industrial organizations, and therefore industrial medicine, were wholly co-operative and democratic, this might not be true. But under present conditions it is to be hoped that medical and health resources will be developed and strengthened as much as possible from community rather than from direct industrial resources.

Industry should do its share as a part of the community, but not more than its share. The initiative and self-dependence of immigrants and their families, and their understanding of the purposes and methods of medical and health work, can be promoted only when they have responsibility and participation as citizens.

Mr. Whiting Williams¹ of Cleveland, in an article printed for circulation by the United States Department of Labor, says:

The price of maximum production is maximum personality for every human producer. Of this, the price is maximum outlet for that human producer's best and biggest feelings. That in turn can be bought only with right relationships and associations with all the persons of his world. Of that the price and the prize is democracy.

¹ Whiting Williams, *Human Relations in Industry*, leaflet printed by the United States Department of Labor, 1918.

XVII

PUBLIC HEALTH WORK

THE health department is the fundamental agent of the community to serve, protect, and advance the physical well-being of its members. Any survey of American policies and methods in medical and health work leads to the health department. Any program of medical and health work must place in the foreground the policies and methods of the health department, as they are or as they should be. In order to secure material for this study public-health officials in all cities of 25,000 population and over were asked to state what special problems they have met in dealing with the foreign born, and what methods they have used in solving them.

From the answers it is apparent that the special problems of health standards and care among the foreign born have made very little impression on the mind of the average health officer. To be sure, one finds striking exceptions to this rule, which only bring into greater relief the indifference of the large majority.

The reason for the apparent neglect of such an important element in health work is clear. Public-health administration, in the majority of cases, is just beginning to come into its own as to equipment, trained personnel, and a modern conception of the powers and duties of the department. With the exit of the "yellow flag" and "shotgun" quarantine methods

PUBLIC HEALTH WORK

have come careful analysis of the causes of disease, and the application of rational methods to its prevention and control.

Valuable answers were received from (116) health officers. As the outstanding health problems of the foreign born, 64 per cent mentioned housing and home sanitation, 44 per cent child and infant welfare, and 32 per cent care of contagious diseases. In discussing these problems all points of view were expressed.

Too often there appeared the attitude that the foreign born "lack willingness to learn the precautions of health." Based on this premise is the inevitable conclusion that the only way to deal with health situations involving the foreign born is the big-stick method. The head of a middle-sized city in New York (Albany) says with emphasis that the only way to control communicable disease among the foreign born is by *police quarantine*. In this he is seconded by one of the larger cities of the Far West (Denver).

It is refreshing to find in Texas (Beaumont) an official who is sure that we can educate the immigrants to believe that the health department is to benefit and not to prosecute them. This feeling is more than confirmed by a Massachusetts (Springfield) health officer of long experience, who says "that they can be educated—that they cannot be controlled by prosecution. Further, that if we make the right approach the average foreign-born person will respond to efforts and carry out our recommendations." A public-health nurse in Massachusetts (North Adams) testifies that "as a rule the foreign born respond to advice and carry out instructions as faithfully as our own people in the same circumstances."

IMMIGRANT HEALTH AND COMMUNITY

Inquiries were made as to methods of reaching the foreign born. Very few, if any, of the health officials in the country have any special program laid out for the foreign born. It is true that we find a great many clinics, public-health nurses, health centers, and welfare centers established in the foreign quarters, but investigation shows that these centers are established to provide general medical care for the poor, and the solution of the problems of the foreign born is of secondary importance.

These methods have been discussed as such in earlier chapters. The point of view of various health officers toward them is significant. The following testimonies are typical. A Middle-Western health officer says:

Force them to use the "American language." We have Welfare Stations with Americans in charge. I will not employ any who talks to them in a foreign language. It is up to them to learn English—not us to learn their languages. I have no patience with less strenuous methods.

With this can be contrasted the statement of the health officer of one of our modern Eastern departments (Newark, New Jersey), who says:

We believe until such time as English is universally spoken we should endeavor to reach the foreigner by all possible means.

He backs this opinion by providing, in every part of his department, a line of communication to the foreign born in their own languages.

Intensive study of certain outstanding experiments in community health work brings out more suggestive evidence than did correspondence. With the exception of a few middle-sized communities, such as Erie,

PUBLIC HEALTH WORK

Pennsylvania, and Bridgeport, Connecticut, the items of interest are chiefly from cities of the first class. In these the health departments have been of sufficient magnitude to develop full-time expert personnel along various special lines of medical and health work, as well as in their general administrative staffs. The large cities have thus naturally served as experiment stations and leaders in professional development. Voluntary organizations supported by private funds have also conducted a number of pieces of work in large cities which are of almost equal interest with the undertakings of health departments.

The most important single step made by health departments toward effective methods of work with the immigrant has been the employment of visiting nurses to do infant-welfare or tuberculosis work, school nursing, prenatal work, or general public-health nursing, including these and sometimes other lines. Formerly, the only point of contact between the health department and the average family was a distant central office, with a formal, if not political, atmosphere, to which people rarely resorted except at the summons of the police or to lodge their complaints. The visiting nurse has taken health work to the people. She has put it into terms of daily personal life.

The same methods which make nursing service under private associations effective in dealing with the immigrant will be successful in state and municipal health departments. Since this technique has already been considered, our present interest in surveying notable developments by health departments and voluntary associations in the same field is in their

IMMIGRANT HEALTH AND COMMUNITY

organization and their relations to other community agencies.

The use of visiting nurses naturally promotes localization. Districting is an obvious means to efficiency in administering visiting-nursing service in any large city. Experience has shown that the tuberculosis, baby, and other health clinics that have developed simultaneously with visiting nursing, are also most effective when brought close to the people. For example, large centrally located clinics for diagnosis and treatment of sick babies are essential, but to do infant-welfare work along preventive lines on any extensive scale it has everywhere been found necessary to have a number of "infant-welfare stations," or local baby clinics, each serving a small, definite area. The visiting nurses have naturally been attached to the clinics.

The developments studied here relate chiefly to methods of intensive localized medical or health work, and to the co-ordination of intensively organized local health districts one with another and with the medical and health work of the city as a whole. It has recently become the fashion to call this the health-center movement, but this term lacks exact definition and is being used to cover a variety of undertakings. It will not, therefore, be employed here except in an illustrative way. The history of its development can be found elsewhere.¹

EXPERIMENTS IN NEW YORK

A certain number of organizations have consciously sought to develop neighborhood co-operation in the

¹ Michael M. Davis, Jr., *Public Health Nurse Quarterly*, January, 1916.

PUBLIC HEALTH WORK

district receiving the health service. One of the earliest, if not the earliest attempt in this direction, was made by the New York Milk Committee in 1913, in establishing a health center on the lower West Side of Manhattan.

The section selected was largely populated by Syrians, with a proportion of Irish-Americans and native born. It was a district with comparatively poor housing conditions and limited medical resources. A thorough canvass of the residents was made during the first two years of the health center. The Bowling Green Neighborhood Association, composed of residents and of friends and specialists from outside, was formed to administer the activities of the center. These were chiefly infant welfare and prenatal work, but the program ran beyond the health field, and illustrated the wisdom of expanding the interests of a neighborhood group beyond a single specialized activity. As an experiment in practical Americanization, the "Bowling Green" undertaking is well worth careful study.

It has been characteristic of almost all these endeavors that they have been conducted in districts predominantly inhabited by comparatively recent immigrants and their children. Thus the most ambitious attempt to apply the principle of localization in the administration of health work was made by the Health Department of New York City in 1915 in a district on the lower East Side of Manhattan, almost entirely populated by Jewish people. The scheme can be most readily shown by the tabulation on the following page.

The health officer of the district was a Jewish physi-

IMMIGRANT HEALTH AND COMMUNITY

cian who understood the people, their language, backgrounds, and characteristics. The three nurses and the nurses' assistant, as will be seen from the tabulation, were each performing several functions, instead of one. Thus, under ordinary conditions, no home would have

HEALTH DISTRICT No. 1

NEW YORK CITY HEALTH DEPARTMENT

FUNCTIONS PERFORMED	DISTRICT STAFF	SUPERVISING STAFF
1. Prenatal work	Health officer of district (part time) in full local administrative charge	Health Commissioner or Deputy
2. Infants' milk station	Medical inspector (part time)	Bureau chiefs of
3. Examination of children, pre-school age	Functions 2, 3, 4	1. Child hygiene
4. Medical inspection of school children	Three nurses	2. Preventable diseases
5. Supervision of midwives and foundlings	Functions 1-7	3. Food inspection
6. Tuberculosis supervision	One nurse's assistant	4. Sanitation
7. Other infectious diseases	Function 2	5. Public health education
8. Food inspection	Food inspector (part time)	
9. General sanitation	Sanitary inspector (part time)	
10. Public health education		

more than one nurse as a visitor. The contacts between the people of the district and the health department were simplified and strengthened in three ways:

1. By visibly localizing the health department's work in an office in the center of the twenty-one

PUBLIC HEALTH WORK

blocks housing the 25,000 inhabitants of that highly congested area.

2. By making a single official, who was chosen for his familiarity with the human as well as the public-health factors of the work, and who was in daily local attendance, the center for most official contacts between department and populace.

3. By emphasizing, through the generalized nursing service—one nurse to a family—the personal elements as distinguished from the professional elements.

It is said that among both the physicians of the district and the general population, a noteworthy increase in efficiency and friendliness developed during the rather short period that this interesting experiment was in effective progress.

This scheme involves the same principle of "line" and "staff" organization with which army procedure has made us familiar, and which is generally applied in public-school systems and other large enterprises. The "staff" is a group of experts, each concerned with a special function or group of functions. The "line" officers and employees are concerned with administering the work in its various functions.

Thus, in this East Side health center, the bureau chiefs were "staff" supervisors, each watching critically the performance of the special functions which came under his or her bureau. The local health officer and the nurses and others under him were "line" officers or employees. Further experiments of this type will be required to establish the desirability of such a scheme of localized health administration. In-

IMMIGRANT HEALTH AND COMMUNITY

herent in it are principles of successful medical and health work with the foreign born.

HEALTH CENTERS IN CLEVELAND

New York City is ~~not alone~~ in the development of district schemes. Cleveland has a system of health centers (at present eight in number, but probably soon to be increased) in charge of the health department. Their work includes tuberculosis and preventive service for mothers and babies, and each serves a definite district.

The health-department nurses do all the work except bedside nursing. One of these health centers is the so-called University Teaching District. The supervising nurse is an appointee of the Western Reserve University Medical School, who retains also a relation to the health department. The five nurses under her have each a special section of the district, and do general and bedside nursing, as well as special work. The training of public-health nurses is also carried on here.

In this district the population is largely foreign born. One nurse has a considerable proportion of Italians; another, almost all Slavs; still another, many Jews; still another, a "great mixture." The localization and districting of the work appears to have brought about much greater interest in the human factors, including the factor of race.

The plan, which divides the district up into small sections, each in charge of one nurse, appears to have interested each nurse in the special problems of her people; to have made her familiar with the particular

PUBLIC HEALTH WORK

racers or other groups characteristic of her area, and to have increased the intensiveness and the extent of both social and professional contacts. The tendency of such a plan is to produce more work than a given staff can carry. This is the best evidence of its success, since the ultimate purpose of such health work is to cause a growing demand for the service. The goal is to meet 100 per cent of the needs.

CO-ORDINATION IN BUFFALO

In Buffalo the health department and the co-ordinate Department of Hospitals and Dispensaries co-operate in administering health centers. Five such centers are maintained in different parts of the city, in each of which infant welfare, antituberculosis, and prenatal work is conducted. Localization is carried still farther in the infant-welfare work by eight "well-baby clinics" outside the centers, but part of the same system. Five district physicians are employed on salary by the Department of Hospitals. Each physician treats the sick in their homes and also runs a general clinic in the district health center, of which he is in general charge. Four of the five health centers have dental clinics. Thus curative and preventive medicine are combined, although not wholly, under a single direction.

The first of these Buffalo health centers was located in rented quarters in a distinctly Polish district, but the development of the service has justified the provision of a new building especially for the purpose. The localization of both preventive and curative work appears to have demonstrated its value to the com-

IMMIGRANT HEALTH AND COMMUNITY

munity in Buffalo. Here again the people to whom the services are rendered are largely foreign born.

A DISPENSARY IN BOSTON

The Maverick Dispensary, Boston, represents a number of agencies brought together in a single building in a district peopled largely by Italians. A general medical clinic, morning and evening, eye and dental clinics for both children and adults, and an obstetrical clinic are included in the curative work of the dispensary proper. The physician who is in charge of the general clinic visits and treats patients in their homes. The District Nursing Association of Boston has its local headquarters in the building. Its nurses do bedside nursing and prenatal work in the district. The local "well-baby station" was formerly in the building, but has been driven out by lack of space. It is, however, in the immediate neighborhood, and works in close co-operation with the dispensary. The local clinics act as referring stations from which patients are sent to the large dispensaries and hospitals equipped for more elaborate work or for major operations.

Boston is as fully provided as any city in the country with general dispensary service. Yet the development of this local dispensary in a section largely foreign born seems to be fully justified during recent years by the rapid and steady increase in the number of cases cared for. The number of visits to the treatment clinics increased from 7,044 in 1915, to 10,859 in 1918, a growth of over 50 per cent. Undoubtedly friendly contact with this local center has served to familiarize

PUBLIC HEALTH WORK

many foreign-born families with American medical resources.

THE SOCIAL UNIT PLAN

Much the most comprehensive attempt to enlist and organize the co-operation of a district has been that of the National Social Unit Organization in Cincinnati. The so-called Mohawk-Brighton District, in which the experiment has been conducted, has a population of about 15,000, between 5 and 10 per cent of which are recent immigrants. These are mostly Rumanians and Hungarians, who live in one corner of the district and are in large proportion men without families. The bulk of the district is a comparatively long settled and stable family population of German-American stock. The findings of the Social Unit Plan are therefore limited in their application to the problems of the foreign born.

Activities up to the time of this writing have been chiefly along health lines, consisting largely of infants', children's, and prenatal work. Medical examinations and advice were given following the influenza epidemic. A statement dated January, 1919, gives an account of the "baby service."

The first service to be established for the neighborhood was a baby service which was decided upon by the Mohawk-Brighton Citizens and Occupational Councils and opened on December 17, 1917. It was found at once that because the block workers were elected representatives of the blocks, because they were neighbors of the babies' mothers, the work of discovering the babies and of interesting the mothers in bringing them to the station was greatly simplified. The doctors and nurses also were neighborhood

IMMIGRANT HEALTH AND COMMUNITY

representatives, and it became a matter of pride to have one's baby examined. It was not considered that the health station was in any sense a charity institution.

As a result of these unique features and of the general educational program on infant care, conducted by the neighborhood itself through its own physicians, nurses, and elected block representatives, in four months every one of the 297 babies under one year of age was under nursing supervision, and 70 per cent had been given examinations by the medical staff. As babies are born, they at once come under the nursing care. Also, the baby service has been extended to include babies between one and two years of age, and at present every baby under two is under nursing supervision. Of these, 410, or 90 per cent, have visited the health station and have had careful physical examinations, and many are returning at regular intervals for preventive oversight by the physicians, being referred to their family doctors for curative care.

This remarkable achievement of reaching nearly 100 per cent of the babies was undoubtedly due to the careful organization of the district, block by block. Each block has its "worker," who is paid a certain amount for the time she gives. The block workers together make up a "council" with a salaried executive, who has an office at the central station of the Social Unit in the district. She is the organizer and leader for her neighborhood.

The six nurses, one of whom gives her time to supervision, and five to field work, get all sorts of information from the block workers regarding the conditions and needs of families, and are thus placed in friendly and intimate contact with the people.

Up to the time of writing, however, very little has been done to connect the men of the district with the health program. This partly explains why it has

PUBLIC HEALTH WORK

failed to reach the Rumanians, Hungarians, and other recent immigrants.

No special attempt seems to have been made to reach these immigrants or to see that some one of their group whom they felt to be representative of themselves and their interests was brought into the neighborhood organization. The block workers seem to have the not infrequent "American" attitude of indifference toward them or at least a strong sense of separateness from them. It is apparent that even a small proportion of foreign born may greatly complicate the neighborhood organization of a community. The plain people, who constitute neighborhood organizations, are not likely to be any more free from race or national prejudice, or to be imbued with any higher ideas of practical democracy than the people who work out schemes for neighborhood organization.

Therefore the Cincinnati Social Unit has not made a contribution toward the closer interrelation of native and foreign born. It was not established with this particular end in view, nor was the district selected one which would make it possible to accomplish much in this direction. The district does, however, contain a sufficient proportion of recent immigrants to make it wise that a deliberate effort be made to work them effectively and democratically into the neighborhood organization before the term of the experiment is completed.

Much of value can be got from the Cincinnati Social Unit for our general program of medical and health care for the foreign born. Its technique of neighborhood organization is capable of general application,

IMMIGRANT HEALTH AND COMMUNITY

with such modifications as would render the scheme simpler and less expensive.

The unit has thrown into the foreground one vital principle. It has taken into its confidence, on a democratic basis, the people who are to be served, so that they understand and appreciate the services and participate in the guidance of its policies. Merely to throw this principle into relief, to illustrate it so that it will be talked about and thoughtfully considered all over the country, has been a contribution of high value.

Part V
A PROGRAM FOR HEALTH

XVIII

COMMUNITY ORGANIZATION

If one needed to be convinced of the seriousness of the immigrant health problem in this country, a glance at available sickness and death rates would be sufficient. The general terms of the situation are as follows. The physical and social environment in which the average immigrant finds himself in America contains elements that seriously menace his health. Unsanitary housing almost automatically falls to his lot. The balance of his dietary is upset by inability to secure familiar foodstuffs. His occupation is changed without a corresponding change in his way of living. His medical service is in large part supplied by the midwife and the quack. His comparative ignorance and his comparative poverty often make it impossible for him not only to secure the best in our complicated society, but even to use the advantages that come under his hand.

The immigrants themselves have made an effort to meet the burden of sickness by organizing benefit societies, but their measures are inadequate to the situation.

American agencies and methods of work with the foreign born are gradually being developed. The nurse, the hospital, the dispensary, the employer, and

IMMIGRANT HEALTH AND COMMUNITY

the health officer have each contributed something, either in plan or practice, to the large problem of the health of the immigrant. Although relatively little serious attention has been given to special methods of work with the immigrant, by most health departments and hospitals, certain promising lines of work have been developed, chiefly in health centers, and a certain amount of technique has been worked out by visiting nurses and social-service workers.

But has there been in any instance a comprehensive plan for the whole situation? Can any one, or all of these organizations, working independently, be said to be adequate? Throughout our considerations of these agencies in their work with the foreign born, an attempt has been made to keep in mind the way the individual immigrant views things. From his point of view has health service been satisfactory? If it has not been adequate or satisfactory, what has stood in its way?

There are four limitations upon the extent and quality of medical care which this part of our population receives. They are economic, psychological, professional, and social. A study of these will give the basis for a more comprehensive plan.

THE ECONOMIC LIMITATION

The immigrant has not enough income to pay for what he and his family need in case of sickness. Recent studies ¹ of the United States Bureau of Labor Statistics have shown that in 1918-19, among a large

¹ *Monthly Labor Review*, United States Bureau of Labor Statistics, November, 1919, p. 19.

COMMUNITY ORGANIZATION

number of families in thirty representative cities, the yearly expenditure per family for health ranged from \$31.27 to \$92.77, averaging \$58. This sum included expenditure for doctor, dentist, oculist, hospital, and medicines. Unfortunately these data do not separate the native from the foreign-born families, so that it is not possible to compare their expenditures.

Previous to the war the incomes of most of our wage-earning population did not exceed \$100 per month per family, and many had less than \$1,000 per year. There must be thousands of cases where expenditure for medical care in ordinary illness is out of the question, and the cost of a grave emergency involves the sacrifice of small savings or actual debt. Unfortunately, it is in this class that a great many immigrant families fall.

It is, however, true that the economic limitation is not wholly a question of income. All immigrants are not poor in the technical sense of dependency. It is a question of income in relation to the standard of living. Families with two or three generations of American ancestry and with incomes, let us say, of \$1,800 or \$2,500 a year, usually include in their conception of life many activities and requirements with which the immigrant is unfamiliar.

In ordinary terms we say that this American standard of living is higher than that of the immigrant. Among other things, the American family is accustomed to provide the service of a private doctor for its members during illness. They allow for this as far as they can in making up their annual budget or in planning the expenditure of their income.

The combination of a so-called low standard of

IMMIGRANT HEALTH AND COMMUNITY

living, with considerable financial reserve in emergency, is a characteristic frequently noted by workers among the immigrants. A doctor tells of an obstetrical case in which the free services of an institution were at first sought, but, owing to difficulty and delay at the critical moment, \$60 was finally paid in cash to a private physician to deliver the woman.

It has not always been appreciated that savings are part of the standard of living in many immigrant families. They pursue a standard of life more or less like that to which they have been accustomed in Europe, with certain adaptations to the American environment. They receive more money wages than ever before, and sometimes put much by. A native family with the same income but a different standard would spend more and save less, because they would be unwilling to sacrifice present comfort, health, or self-development. The immigrant does not appreciate that he is making a sacrifice.

It is only gradually, as he becomes accustomed to American wage scales, American living conditions, American opportunities, that he begins to adjust his spending and his saving to what we call the American standard. Before this happens there is a tendency to cut down the use of the more expensive forms of medical care until the critical stages of disease, usually too late for the best medical efforts to yield full results.

THE PSYCHOLOGICAL LIMITATION

People have inadequate, false, or foolish conceptions about their own bodies and about the influences which make for health or disease. Different levels of

COMMUNITY ORGANIZATION

understanding are admirably illustrated among immigrants.

To the primitive mind, healing seems a form of witchery or magic. An advertisement, clipped from a Polish newspaper, read as follows:

If you have love troubles, write me. I have something that never fails. Mrs. Blank . . . Street.

A complaint was actually received by one of the staff of this study through the editor of the paper in which this advertisement appeared. A trusting Pole had read the advertisement, and, feeling that his wife's affection for him was on the wane, wrote to Mrs. Blank. He learned that for \$12 she would send him a love potion in the form of a powder, which, put into his wife's tea, would certainly restore his happiness immediately. He sent the \$12. Unfortunately, the package arrived in the absence of the man of the house, and was opened by his wife. She threw it away, and what she said to her husband he failed to repeat to the editor. He did not lose hope, however, but again wrote to Mrs. Blank, telling her that the powder had been lost through accident and asking her to send him another. She refused, but after more correspondence agreed to send a second package for an additional \$6. By this time, however, the man had become disgusted and complained to the editor of the paper in which he had seen the advertisement. The editor seemed to feel rather helpless about the matter, but turned the correspondence over to us.

Somewhat less primitive is the reliance on medicine. Upon still another level is the conception of medical treatment as a "system," according to which each

IMMIGRANT HEALTH AND COMMUNITY

disease has certain symptoms which are dealt with in certain ways according to certain rules which doctors know.

The patient's failure to understand the doctor's work may be almost as serious a limitation upon the efficiency of medical treatment as lack of skill in the doctor himself. Only the most patient, tactful, pains-taking course of explanations and instructions can persuade an uneducated adult to take a disagreeable treatment or to change his occupation or many of his life habits, when the doctor believes that his health requires one or all of these things. The foreign born are by no means the only people who do not understand the principles of hygiene and the nature of disease; but certain points due to this lack of understanding are thrown into high light among them.

THE PROFESSIONAL LIMITATION

Many of the doctors, hospitals, and dispensaries accessible to the foreign born are on a low plane of efficiency. The nature of the private doctor's work with the foreign born, and the low income received, tend to draw into and retain in immigrant sections physicians who have not received the most recent or best medical training. Severe competition often prevails which puts a premium on commercial rather than on professional ability, and tends to lower rather than raise the standard of medical care.

Medical science has grown beyond the mastery of any one man and now requires specialization of skill. The conditions prevailing in immigrant districts practically limit the physicians who reside there or who do

COMMUNITY ORGANIZATION

most of the local work, to general practice. The population can usually gain access to the specialist only by going to hospitals or dispensaries as charity patients.

The practice of medicine once required the physician's personality, his brain, and his trained eye and hand, and only a few simple inexpensive instruments for diagnosis and treatment. The practice of medicine to-day requires an elaborate and expensive equipment—manifold instruments, X-ray apparatus—and extensive laboratory service, if the best diagnostic and therapeutic results are to be achieved. To conceive that such equipment could be available to every practitioner in his private office under his individual control is out of the question, nor could any one man learn to use all of it if he had it.

There are various exceptions to these general statements. Yet in the main they are true. The defect here is called a professional one, but the medical profession is less to be blamed for it than the community.

THE SOCIAL LIMITATION

The general public has failed to keep abreast of the development and possibilities of medical service. The practice of medicine now requires community aid if the physician is to have sufficient capital for equipment and sufficient facilities for working with specialists.

The organized practice of medicine appears in many hospitals and dispensaries where elaborate equipment is provided which many doctors can use, and where the different branches of professional skill are so

IMMIGRANT HEALTH AND COMMUNITY

organized that teamwork and group medicine are facilitated. But thus far such organization has been only within the limits of institutions, to which a comparatively small number of physicians have access, even in large cities. Specialists are few in number, except in large cities, and high priced.

The work of the specialist and the institution is, as a rule, inaccessible to the immigrant on any but a charity or semicharity basis. The need of a community organization of medical service which shall be exclusive enough to provide the best facilities for medical care "to all the people who need them and all the doctors who know how to use them" is as yet nowhere realized.

We see the need of such community organization most strongly in the small city or town. In some industrial communities, for example, where from 50 per cent to 90 per cent of the population consists of foreign born and their children, there is only one hospital, and that hospital is chiefly for patients who can pay. There is usually no dispensary, and most important of all, only a very small proportion of the doctors of the town have access to a laboratory, an X-ray department, or to the consultation privileges of the hospital staff. There are few, if any, specialists in a small community, for there are rarely enough people to support a skilled oculist, a throat and ear specialist, an orthopedist, or a pediatricist.

In many large cities the sections thickly populated by immigrants suffer under the same conditions, but in the large city better facilities can be obtained by going to institutions or physicians in other sections. Only by a city-wide organization of medical service, with

COMMUNITY ORGANIZATION

institutions related to one another and to general medical practice, can such conditions in cities be remedied. Only by organization on a state-wide basis can the gross deficiencies of the small cities and towns be made good.

By what means shall the extent and quality of medical care among the immigrants be improved? Many of the characteristics of our present system of medical service, which militate against the immigrant, militate also against the native. A system must be developed which can give adequate service to all people of small means and little health knowledge. Given this fundamental improvement, farther adaptation to the needs of the foreign born will not be difficult. The peculiar terms of the immigrants' condition intensify every general difficulty, and also create special problems, but dealing with these is a matter of technique, the specialized application of sound general principles.

HEALTH INSURANCE

Health insurance is one measure proposed for improving the medical care received by the masses of the community. It is aimed particularly at the economic limitation. While it does not apply separately to the foreign born, its application would include them. Health insurance, as it has been most seriously discussed in this country, follows more or less the lines of the British and German systems. It is formulated most definitely in the so-called Model Bill of the American Association for Labor Legislation.

The provisions of such a law require that all wage

IMMIGRANT HEALTH AND COMMUNITY

earners—or possibly only those up to a certain limit of income, or in certain occupations—be insured. Insurance groups are formed along local, occupational, or establishment lines. Existing fraternal or industrial societies can thus be recognized. The insured pay a portion of the expense, the employer a portion, and the state may also pay something, either directly or by meeting the overhead expenses of administering the system.

Various benefits are contemplated. Cash, amounting to one half wages, is given during the period of sickness up to twenty-six weeks in one year. In addition, medical care is provided the insured person. Bills which have been considered by some state legislatures give medical care to all members of the family. Some of the bills provide for dental and hospital care, and for nursing service; some for a maternity benefit; and most for a small cash benefit, not exceeding one hundred dollars, to cover the immediate funeral expenses of the insured person.

Such a scheme of health insurance obviously seeks to prevent the expense of sickness falling upon the individual with crushing force at the very time when he and his family are least able to bear it. The proportion of persons who are ill at any one time are cared for by the continued payments of those who are well. This is simply the application of familiar principles of insurance long established in other fields. The essential idea is to distribute the burden of a risk. The fundamental virtue of the proposal is that sickness is inherently an insurable risk, and that the burden ought to be distributed, not only for the sake of the suffering individual, but for the sake of the

COMMUNITY ORGANIZATION

community as a whole, which in the long run has to pay the bills when sickness forces families below the level of self-support.

Many of our immigrants come from countries in which health insurance has long been in existence; moreover, the habit of co-operative association for mutual benefit is much more highly developed among our foreign-born population than among the native. Health insurance should, therefore, be peculiarly effective in the case of the foreign born.

Under health insurance the family could secure medical service without incurring a heavy financial burden. Health insurance, however, would not remove the psychological, professional, and social limitations upon the efficiency of medical practice. The patient's ignorance of hygiene and of how and when to use doctors, would not be directly altered by health insurance. The insufficient training of doctors, the lack of equipment and of opportunity for consultation, are faults not corrected by any of the systems of health insurance existing abroad. Some of the bills proposed in this country mark an advance in this direction.

The system of medical care under health insurance ought definitely to be designed to provide that there shall be pooling and organization of medical resources, and not merely that isolated individual practitioners shall be accessible to more people. Great Britain made the mistake of fastening upon the state a system of medical service which was the most efficient known in the middle of the nineteenth century, but which is a generation or more behind that obtainable in the second decade of the twentieth. Some health-insur-

IMMIGRANT HEALTH AND COMMUNITY

ance bills recently discussed in our legislatures would result in the same error.

On the whole, health insurance seems to be the largest single step that can be taken toward reducing the economic limitations upon the extent and quality of medical care among the foreign born. But it will be worth while to delay the enactment or operation of a health-insurance law until a scheme of medical organization can be included that will remove as fully as possible the other limitations upon the efficiency of medical care.

COMMUNITY ORGANIZATION OF MEDICAL SERVICE

Medical service should be organized on a state or community basis. This would mean the co-operation of public and private agencies to use all the medical resources of the community to the best advantage. It is desirable that we have higher levels of education in our medical colleges, better systems of licensing medical practitioners and perhaps of supervising them after licensing. Yet these measures solve only part of the problem. In addition, better medical facilities must be placed at the command of the practitioner, and to do this medical facilities must be organized on a community basis.

This does not necessarily mean the control and direction of medicine and the employment of doctors by the state. It does mean recognition by public authorities that technical facilities for diagnosis and treatment have grown beyond the point where the average physician can possibly provide his own. The public has a direct interest in getting good doctoring. It should assist financially in such provision.

COMMUNITY ORGANIZATION

Such a general community plan will remove the professional and social limitations upon adequate medical service. It is probable that through it the psychological limitation can finally be removed. The process of education must work its slow course. The only accelerator is the adaptation of the methods of health work to the psychology, the backgrounds, and the characteristics of the people for whose benefit the work exists.

Let us have in mind that a program of medical and health service to a community is not a program of charity. Only a narrow and inadequate conception of such service limits it to the poor or to any special section of the community, such as the foreign born. Special adaptation in policy or method of work to the peculiar needs of certain sections, such as the foreign born, is wise and right, but the scope of the service as a whole should be broader than any section. The more that medical and health facilities are used by many social classes, the easier it will be to maintain a high standard and secure sufficient appropriations.

THE LOCALIZATION OF HEALTH WORK

One of the primary considerations in a community plan is the localization of health work, the units of area or population selected for service, or for recruiting personnel and finances.

In the health center established in New York City by the Department of Health in 1915, 25,000 Jewish people were included in the health district. This population, however, was living in tenement houses, mostly five stories high, with four families to a floor,

IMMIGRANT HEALTH AND COMMUNITY

so that the whole area of the district was less than one eighth of a square mile. Under such conditions it is necessary to use a smaller unit of area and a much larger unit of population than in such a town as Framingham, Massachusetts, with two thirds the population. The district selected by the Social Unit in Cincinnati has a population of 15,000 living in small houses. The area covered is perhaps six times that of the New York health district, with only about 60 per cent of the population.

In outlining the boundaries of a district racial lines may have to be taken into consideration. For example, there are localities in which the population of one nativity stops suddenly at certain streets, and it may be wiser to have a district of fairly homogeneous population than one containing two race groups. The number of the population, the degree of congestion, the race constitution, the existing political boundaries, such as wards or precincts, and finally the topography, must all be taken into consideration in determining the unit within which a health center is to work. The size of the staff will depend upon the population and area.

GENERALIZATION IN FIELD WORK

The selection of small units for health service has raised the problem of so-called "generalization" in field work. In this sense generalization means the performance of several functions by a single worker. Thus, instead of infant-welfare work and antituberculosis work being conducted each by a separate corps of nurses within the same district, one nurse with a smaller district carries on both. Historically the de-

COMMUNITY ORGANIZATION

velopment of health work in the United States was through the establishment of one specialty after another. The movement toward generalization thus tends to break some established lines. Does anti-tuberculosis work suffer in quality if a nurse also does infant work, or bedside nursing, or school nursing, or all these?

The extent to which generalization is practicable is a question of degree, which will not be answered alike in all communities. Success in generalization depends very largely upon the people who are doing the work. A higher, not a lower, degree of skill and personality are necessary in the generalized worker, compared with the specialist. Many of the experiments, and the extension of almost all of them, wait upon securing a sufficient number of competent persons.

A large proportion of local health centers have been in districts particularly foreign in population. Our survey has perhaps made it clear that the less familiar the people are with American conditions and with the technical phases of medical and health service, the more attention must the health worker pay to the human and personal elements.

In general, it may be said that the less knowledge of medical and health matters the people have, the more should the worker have. It requires more, and not less, tact and training to explain the care of a baby to an ignorant mother than to an intelligent mother. The simpler the type of mind that is to be dealt with, the simpler and more elementary must be the terms of the message. The most obvious and elementary points are often those of greatest importance, and most of these obvious and elementary points

IMMIGRANT HEALTH AND COMMUNITY

are very similar in all forms of medical and health work.

Generalization, therefore, throwing emphasis upon the personal instead of the technical elements, is particularly applicable to work among the foreign born, provided always that we have workers with the necessary qualifications. Medical and health work with the foreign born places an emphasis upon personality and upon understanding of people, more than upon skill in technique, and only through personality and understanding of the people can results in technique be realized.

SERVICE ORGANIZATION

The unit of area selected for field work should *not* be the same as the area from which professional services are to be drawn. A much larger unit of population is necessary to supply all the various facilities and personnel which are included in a complete medical and health service. The Social Unit in Cincinnati has proceeded as if the personnel, at least for the medical service, must be drawn from within the same area as that selected for field work. Proceeding on this theory, specialists in pediatrics and obstetrics, for example, could not be included. In selecting the nonmedical personnel, such as the nurses, this theory was not applied.

In the Framingham Community Health and Tuberculosis Demonstration this mistake has been avoided, and outside physicians have been brought in to see patients at the request of local physicians or at the patient's own desire. As a result, the physicians of the community are provided with expert consultants

COMMUNITY ORGANIZATION

without interference with their practice, and the people receive a quality of service which, under ordinary conditions, would not be available to them.

All the factors necessary to a complete medical and health service ought to be available for every neighborhood in every area of a community or of a state. The professional personnel of the neighborhood must not be the sole, or the determining, factor, but a co-operating element in the organization of professional services.

In many small cities and towns there is a sort of local self-consciousness, or pride, which renders it difficult to include so-called outside talent in the service organization. A very worthy human sentiment is at the basis of this feeling, but a thorough understanding that the community can secure satisfactory service only if a broader area is drawn upon will go far to render the right plan practicable. This is especially important in case of the emergency needs of epidemic or disaster.

The right kind of service organization includes specialists; *e.g.*, oculists, orthopedists, psychiatrists, experts in the diagnosis of tuberculosis, who visit the appropriate clinics in the community just so often as is necessary. A small town may require one half or the whole of a dentist's time for the school children, or for the public in general. Psychiatrists for a mental clinic would be needed by the same community only once a month or even less often. The nature of the work, or the relative frequency of the particular diseases in a population, determines the time required from different consultants and specialists.

The service organization must include state as well

IMMIGRANT HEALTH AND COMMUNITY

as local or county personnel and functions. The experts or the district supervisors of the state health department should furnish organizing ability and a standardizing influence. We have good examples of this in the administration of the venereal-disease program in a number of states during and since the war.

Health literature for use in clinics and in the homes can be more efficiently and economically prepared by a state or national organization than by each local community for itself. The diagnostic facilities of a state laboratory should be, as they are in many states to-day, made available to physicians and clinics in every community. Expensive equipment, such as an X-ray outfit, should be provided for such an area or population as can utilize it fully. So should a hospital, or a dispensary, with all its varied diagnostic and therapeutic apparatus.

DISTRIBUTION OF THE FINANCIAL BURDEN

The expense of health work must be distributed over an area sufficiently large to equalize local resources with local needs. Whereas the need for medical and health work is almost exactly in proportion to the number of the population, the financial resources of an area are not by any means determined by the number of people living in it. The financial power or tax-paying ability of an industrial city or a well-to-do residential suburb may be many times greater than that of large rural areas, including an equivalent population. Yet the interests of the city in the prevention of disease, the promotion of a wholesome life



COMMUNITY EQUIPMENT FOR HEALTH EDUCATION

IMMIGRANT HEALTH AND COMMUNITY

for the state as a whole, and of industrial efficiency in the workers, give its residents, its business men, and its taxpayers a direct interest in better medical and health service for the country and the state.

It is proper and fitting that the local community organization should bear the primary financial responsibility of local medical and health service, but a larger area (sometimes the county, sometimes the state, perhaps the Federal government) may well share certain expenses. The venereal-disease campaign, financed in part by national and in part by local funds, and the work of vocational education, financed partly by state and partly by national funds, have begun to make the application of this principle familiar to the people at large.

The organized use of hospitals in one community by those in smaller neighboring communities or rural areas, is now possible, with the development of motor transportation. The possibilities of transportation make very small hospital units (twenty beds or less) rarely necessary, because larger units, better equipped and more economically administered, can be used not only for obstetrical and all forms of emergency service, but for general medical and surgical work as well. Small local units are necessary in most instances only as first aid or temporary relief stations.

The provision of nurses is properly a function of the local organization, but state or county aid should be provided in organizing nursing service and in standardization and general supervision of its work. It would be an appropriate and requisite health measure for some states to subsidize visiting-nursing service in certain sections.

COMMUNITY ORGANIZATION

Just as local areas may combine to render their hospital and clinic service more efficient, so, as has often been suggested, the combination of areas to employ a full-time health officer is much to be encouraged.

In communities having a large proportion of foreign born, the special difficulties of overcoming the barriers of language, and social and racial cleavage, are often so great that special assistance is necessary. This assistance might take the form of trained personnel loaned to deal with the particular race groups of the locality or to start the local people on the right methods; or it might be a financial subvention as such, to be administered by the community organization with some supervision or advisory aid from the larger area. The state or national government, or such a body as the Red Cross, might provide this assistance.

No large city would tolerate the notion that each ward should pay by itself for its own public schools. The wards that need the best service would in many cases have the poorest schools. The same principle holds when we compare the large cities with the small towns and rural communities of the state. Communities are even more immediately interdependent in relation to the spread of disease than in matters of education. The state, as a whole, must be brought to recognize the interest of all its parts in the health of every member, and to equalize the distribution of the financial burden.

PARTICIPATION BY THE COMMUNITY

With the people of the town or city or district must rest the demand for service, the decision as to what

IMMIGRANT HEALTH AND COMMUNITY

the service shall be, and the general policies under which it shall be provided. Any other program is neither democratic in theory nor practicable under American conditions. Except in times of emergency, such as epidemic or disaster, the state should not take initiative or authority out of the hands of the locality.

On the other hand, it is essential that the locality shall be brought to recognize its own needs and that these needs cannot be met unless the organization through which service is to be provided is more comprehensive in material facilities and personnel than the local community itself can usually furnish. This is the first educational task to be undertaken. The educational method that leads to success is partly through the written and personal presentation of facts, but largely through beginning, step by step, to provide services for which there is a demand.

This is an easy principle to perceive and a difficult one to apply. It is much easier for the professional workers to make their own plan and carry it out for a city or a district, than it is to consult the people who are served. Yet, in the long run, the best understanding of medical and health work, and the maximum results in health education, can only be secured by a process in which the people participate.

In private health organization, such as the tuberculosis committee or the visiting nurses' association, the board of trustees represents the lay public and supplies the needed balance for the professional workers. But such boards of trustees rarely, if ever, represent the people who are served. In public organizations, such as a health department, the mayor or town council represents the public and is nearer to the

COMMUNITY ORGANIZATION

average man's point of view than is the average board of trustees. But there is needed in addition, in either private or public organization, some group representing the people who are served. This idea has been most fully worked out in the Cincinnati Social Unit.

The principle of co-operation is particularly important in health work with the immigrants. It can be achieved directly or through representatives, who stand between the professionals and the laymen and help to interpret one to the other. As a rule, the most ready means of securing direct contact with immigrants and co-operation from them is through leaders of various races or organizations.

The priest is often a most important helper. Foreign-born business men, officials of immigrant benefit, fraternal or nationalistic societies, are usually to be found in any community or district where there are many foreign born. The foreign-born doctor has been discussed at considerable length in preceding chapters. The extent to which medical and public-health agencies can secure and utilize co-operation from him, depends chiefly upon the individual. At least, it is wise to secure sufficient contact with the foreign doctors of a community or neighborhood to decide how far their co-operation or their actual participation in certain medical or health work will be wise and practical.

The local health center or clinic may develop a local neighborhood organization. Usually it is not difficult to *start* health committees or general citizens' committees; it is difficult to *keep up* continued interest and activity on the part of such groups. If co-operating committees of the foreign-born people in a neighborhood are to be not only organized, but kept

IMMIGRANT HEALTH AND COMMUNITY

active and continuously helpful, properly trained people must devote a considerable amount of time to this task.

It is often a question whether it is wise to develop special health committees in a small neighborhood. The problems are usually technical, and after certain general questions of policy have been discussed, there seems little for the committee to do. Where it is possible for a local committee to have general civic functions, a variety of different interests on the part of the members can be appealed to. By the time that one question has been worked out another in a different sphere has arisen. Thus any neighborhood organization for co-operative medical and health work can best be made part of the general civic organization, a local Community Council, for example.

The question also arises whether it is better to have one central organization in a community rather than a chain of neighborhood organizations. In many communities of moderate size a certain number of immigrant leaders could be found who would be valuable advisers for the medical and health work, and who would help on many other local problems. Unless it is clear that sufficient time and effort can be devoted by trained people to keeping up a number of neighborhood organizations, it will often be better to have a central community organization, bringing in the chief elements among the foreign born. It is, of course, desirable to have both if circumstances justify it.

In general, the practical steps to take are:

First: Informal contacts with immigrant leaders of various groups.

COMMUNITY ORGANIZATION

Second: The organization of these on a general community basis, as part of a general Community Council, or as an Americanization committee, or as a separate health committee, if there is sufficient special interest to warrant that.

Third: The development of local neighborhood committees affiliated with or independent of the central body, according to conditions.

In some cities the so-called Americanization program has developed just such community committees. The Cleveland Americanization Committee furnishes an excellent illustration of this. Such a central body can be of service to all types of medical and health work, from local health centers to large hospitals. Not only can the members of such a central committee be directly useful, but they can assemble local groups of their own people when necessary, or help in forming local organizations. Such a general committee is in a position to assist every locality in building up co-operation between local professional workers and the people of any race in that district. It is difficult to arouse and maintain co-operation between the residents of a district, a town, or a city, and the professional workers who come to render definite services. The difficulty of this task must be recognized, but its fundamental importance must never be forgotten. At bottom, it is the task of realizing democracy.

PREVENTIVE MEDICINE FOSTERED THROUGH CURATIVE

A program of community health work is particularly adapted to promoting preventive work as well as

IMMIGRANT HEALTH AND COMMUNITY

curative. Preventive medicine is free from the commercial element and applies to all individuals in a community, native and foreign born alike. For this reason it is very suitably a public function.

There is a great psychological obstacle, however, to preventive work with the foreign born. When an immigrant is suffering, he is ready to seek care. But to approach a well man or woman with excellently intended hygienic advice is a difficult proposition. It is a sound principle, borne out again and again by this study of the foreign born, that curative medicine provides an approach to preventive. Our goal is to teach people how not to get sick, "how to be healthy and well." But we generally find that the best way to get this instruction accepted and put into practice by the recipient is to give it when the recipient or some member of his family is sick or threatened with sickness.

When we are dealing with people of such advanced education and consequent openness and flexibility of mind that they will receive from any competent authority instructions in hygiene, in the care of children, in the prevention of infection, and put them into practice without prejudice or hesitation, then our method of approach can be neglected, and the pure light of science need be the only guide of the public-health worker. But in dealing with our immigrants or other persons whose previously formed habits or prejudices are strong and definite, and whose circumstances may not permit an easy conformity to ideal hygienic conditions, then our method of approach is of fundamental importance if we are to expect practical results from our efforts toward prevention.

COMMUNITY ORGANIZATION

That curative work furnishes the best approach to preventive has been fully recognized in the practice of most organizations carrying on extensive field work. This is notably true in visiting nursing. The original work of the nurse was at the bedside. What she brings in womanly sympathy and in professional skill are two offerings which it requires no interpreter to make clear to the crudest intelligence when acute sickness is in the home. The recent influenza epidemic brought this out in a dramatic way. Much testimony was secured from immigrants, from physicians, and from nurses during the winter following the 1918 epidemic that the nurse who went into the homes during those desperate weeks to give sorely needed service, had an approach to the family and won a sympathy which furnished a splendid basis for purely educational work.

In the field of preventive medical and health work, therefore, we see that there is particular need for emphasizing our initial principle that the study of people must run parallel to the study of technique. As a corollary to this, curative work must be connected with preventive work, so that the service which the people seek of their own initiative can be supplemented by the service which we believe the larger interests of all require. Give a man what he wants when he wants it, and he will be ready to take what he needs when you offer to give it.

A SMALL COMMUNITY PROGRAM

The objection is often raised that community programs for health are too often adapted only to the

IMMIGRANT HEALTH AND COMMUNITY

large city, where there are many health agencies and abundant financial resources, while it is often the small community that is most in need of a comprehensive health program. Since half of our population live in villages or rural districts, and more than 70 per cent in communities of 50,000 or less, too much thought cannot be spent in considering the small community's health problem. The large city has been the experiment station for technique, where methods in school work, health work, recreation, and countless other human activities have been initiated and tried out. The small community is the place where these policies and methods must be applied if they are to reach the mass of the people.

The foreign born, too, are frequently regarded as a problem of the large city exclusively. It is true that New York, the great port of entry for immigrants, has gathered its millions of foreign born and their children, and that other cities receive them in large numbers.

But some important race groups, notably the Scandinavians, have settled primarily in rural areas and small towns. An increasing number of the Italians, Poles, and other Slavic peoples have moved to the country, where the agricultural life to which they have been accustomed abroad can be resumed.

It is even more common to find the immigrant in the industrial community of moderate size. For most of the heavier and less skilled kinds of work in manufacturing and mining, we have come to depend so largely upon immigrant labor that an enormous emigration of the foreign born to these middle-sized communities has taken place.

COMMUNITY ORGANIZATION

There is no inherent reason why the principles discussed here cannot apply to a community of any size. As a matter of fact, it is in a small place that the most comprehensive plan yet made has been tried out. "A program of clinical activities for towns of approximately 20,000 population" was worked out in 1918 for the Committee on Dispensary Work of the American Hospital Association, by Dr. Donald B. Armstrong, the executive officer of the Framingham Community Health and Tuberculosis Demonstration.¹ Step by step he has put it into actual practice in Framingham. A portion of the plan is reprinted here:

ESSENTIAL OBJECTS

The essential objects in the development of any clinic program in such a community would include encouraging the town to recognize its medical and health clinic needs and to try, through public and private channels, to meet these needs. This would probably involve the definitizing of opportunities for community service. The hospitals and other existing treatment agencies should be encouraged to see the community as a whole and not to deal exclusively with individual cases. It is essential to protect the hospital and therapeutic facilities by a bulwark of clinical agencies, thereby heading off many potential patients from hospital treatment by means of education, preventive advice, and early treatment of incipient conditions. These clinics should serve primarily to decrease the need for hospital treatment, and not primarily as an avenue into the hospital.

The clinic service should be put on a self-respecting, self-supporting basis, thereby encouraging adequate medical attention to the class of individuals who fall between the very poor and the very wealthy. The result would be a

¹ Donald B. Armstrong, M.D., "Program for Clinical Activities for Towns of Approximately Twenty Thousand Population," *The Modern Hospital*, vol. xii, no. 3, March, 1919.

IMMIGRANT HEALTH AND COMMUNITY

consequent improvement of medical practice in general, with its elevation and standardization.

COMMUNITY NEEDS

The clinic needs of a community of this size are in general as follows: (1) preventive, educative, health creative; (2) disease detective, eliminative, suppressive; (3) curative, therapeutic.

PROGRAM FOR MEETING THESE NEEDS

The hospitals of a small community are, together with the health department, its chief centers of organized service for health. The provision of clinics for a community should be based upon, or at least closely connected with, its hospital or hospitals. The hospitals have medical equipment and often have space which can be used for clinics with great advantage.

The practical clinic needs of a community fall into two classes: (1) clinics for public health work, and (2) clinics for diagnosis and treatment. The two groups, however, overlap considerably in their practical operation, both as to machinery and field.

The public health clinics grow out of the demand upon the health department to meet the medical needs of a community. The clinics for diagnosis and treatment grow out of the demand upon the hospital to meet the same needs. By co-operation of the hospitals with the health department, or such voluntary agencies as tuberculosis committees, and by co-ordination of the actual work done by all these agencies, the most efficient service will be secured with the greatest economy.

I. PUBLIC HEALTH CLINICS

1. *Prenatal and Infant Work.*—In the establishment of infant clinics in a small city the essential considerations are at least in part as follows:

The work should be designed to reach both sick and well babies, should be partly therapeutic (in co-operation with local physicians and institutions), and should be largely

COMMUNITY ORGANIZATION

educational, covering the needs of infant hygiene, feeding, etc.

In most communities, infant clinics may be essentially educational and consultation establishments; in some places they may also be milk stations.

The work should be associated with infant-welfare nursing, both prenatal and postnatal in character, and a prenatal clinic for the examination and advice of expectant mothers should be closely associated with the infant-welfare clinic whenever possible.

While the clinics themselves are essential for consultations and publicity, they are, perhaps, from a practical point of view, less important than the home nursing and advice associated with clinic work. Constant medical attention is essential at the clinics, with expert pediatric and obstetrical medical advisory service in difficult cases. The medical service should be paid for. The clinics may possibly be made partly self-supporting.

These clinics may be held in school buildings, community centers, etc., and should number from two to four for a community of this size, being held weekly in each neighborhood. One prenatal clinic a week will usually be sufficient. Preferably, the infant-welfare work should be under the auspices of the town's official health agencies, though it may be established under private auspices.

2. The Preschool Period—From a practical point of view it is somewhat artificial to consider this age group separately. Ordinarily, the needs of this group, particularly in a small city, can be met by the infant or school health machinery. Important points for this group are:

The work should pay special attention to educational hygiene, feeding, and nutrition, the detection and elimination of physical defects, etc.

The tuberculin testing of large groups of children in this age group will throw light on the prevalence of infection, may indicate the need for special measures, may emphasize the need for milk pasteurization, and will furnish valuable scientific data regarding the probable age at which tuberculosis infection ordinarily occurs.

IMMIGRANT HEALTH AND COMMUNITY

Work in this group should be under the auspices of the community's health authorities and may be supervised by the board of health or the school committee, depending upon the arrangement in the particular community.

This work, as well as that with the school children, may well be associated with summer health-camp activities and in most communities be made partly self-supporting.

3. *The School Period.*—This work must be of necessity both diagnostic and therapeutic in character. The work of examining and detecting disease or defect is done partly in the school and partly in the clinics. The curative work is primarily for the clinics. This service should be closely allied with the health educational work in the schools along other lines, the recreation and athletic work, the hygiene instruction of both pupils and teachers, the physical educational activities, the open-window room work, the school-lunch provision, etc. The staff for a town of this size would include a full-time physician, two full-time nurses, and such specialists as can be provided in the clinics. A dentist is particularly needed.

There should be at least one central dental clinic connected with the main clinic for diagnosis and treatment, and there should be substations, if possible, established in school buildings, community centers, or factories. In the evening the facilities should be open to the public on a pay basis under other auspices, perhaps, than the board of health or school committee.

An eye-refraction clinic should be established, possibly in the high-school building, but preferably as part of the main clinic for diagnosis and treatment. A nose and throat clinic should be similarly established, probably at the hospital.

All of the clinic work should be primarily on a pay basis, as it is essentially therapeutic in character, special provision being made for necessitous cases, after investigation. It should be carried out in close co-operation with the local industries, local hospitals, community centers, etc.

4. *The Industrial Group.*—Industrial clinics should be medical and dental in character and should be operated in

COMMUNITY ORGANIZATION

close co-operation with other community agencies. Work should be largely diagnostic, cases needing treatment being referred to local physicians or medical clinics, except where minor or emergency problems are presented. Single industries employing from fifteen hundred to three thousand employees should have independent clinic establishments, with at least one full-time physician and two nurses. Smaller industries, providing at least first-aid rooms, may combine for part-time medical and nursing service or may make an arrangement for service with one or another of the clinics for diagnosis and treatment. In connection with the medical and nursing work a certain amount of outside work among the families of the employees may cautiously be developed, to be carried out in co-operation with school, district nursing, and other activities. All of this work, for the sake of uniformity and standardization, might preferably come under at least the advisory supervision of the board of health, if that agency employs a full-time medical officer of health. Part of the time of this official may possibly be given to the minor industries on a part-time basis.

5. *Tuberculosis*.—In addition to the medical and sanitary staff of the local board of health this work will require at least the full time of one tuberculosis nurse, who will divide her time between the clinic and the home work. The clinic should be under the direct supervision of the board of health, located centrally, possibly with substations in convenient places in outlying neighborhoods in the community.

II. CLINICS FOR DIAGNOSIS AND TREATMENT

Certain essentials regarding these clinics may be briefly indicated as follows:

The medical clinics in a community of this size should be established under the joint auspices of the local health and private hospital authorities. They should be located in conjunction with the hospitals, as an out-patient service, and should be made as nearly as possible self-supporting. They should furnish the treatment end for the diagnostic work being done in the infant clinics, in the schools, and in

IMMIGRANT HEALTH AND COMMUNITY

the factories. Local medical talent should be employed in the routine work of the clinics, under expert supervision, associated with a specialist consultation service, possibly developing gradually a certain amount of specialization on the part of the local physician.

These clinics should be operated, so far as possible, on a pay, self-supporting basis, with compensation for the medical staff.

This medical clinic work is an essential factor in any complete community organization for the prevention and cure of disease. It is an essential supplement to the infant, school, and factory educational and diagnostic work. It is necessary in order that all lines of approach to the health of the community may be made to function to their fullest advantage. It is a vital factor in any attack upon the community's death and morbidity rates. It must include both medical and surgical service and such of the specialties as can be added, depending on local conditions. If there are two hospitals in the community which need to be considered from the point of view of co-operation, the medical work may perhaps be carried out by one, and the surgical or some of the special work by the other.

The functions of the medical clinic should include the making of routine health examinations in co-operation with an expert consultation service, the chief object being the detection of incipient disease and the establishment of preventive measures. Possibly this medical examination work may be fostered by private agencies through the development of medical examination groups among the lay citizens.

The clinic should provide a general medical service, both for minor ills and for the more serious chronic affections, such as the cardiac, gastro-intestinal, and other cases.

If many sick babies and children have to be cared for, a special pediatric division should be provided.

In the surgical clinic special attention should be given to the minor surgical cases. This clinic may do industrial accident work for small local business enterprises.

As to the special clinics, all of these will strengthen

COMMUNITY ORGANIZATION

one another and add greatly to the value of the general medical and surgical clinics, if all are held in one building and under one organization. Ideally, they should be the out-patient department of the hospital of the town. Where this is not possible, some of the specialties may be in quarters provided directly by the board of health or school board.

The eye clinic and the ear, nose, and throat clinic should do both school and adult work. An orthopedic clinic is very desirable, if a visiting orthopedist can be obtained, even if infrequently. The dental clinic is an essential service for children and adults (see above). A venereal clinic should be operated at least partly in the evenings and should be co-ordinated with national and state programs to combat syphilis and gonorrhea.

III. THE COST

A very rough indication of the probable gross cost of such health-clinic machinery, both to the community and to the private agencies, may be indicated as follows:

A. The Town Itself

1. A school physician (\$2,500), a board of health physician devoting part of his time to industrial work (\$3,000), and an infant-welfare clinic physician (\$300).....	\$5,800
2. A part-time dentist.....	700
3. An infant-welfare and preschool nurse (\$1,200), two school nurses (\$2,200), and a tuberculosis nurse (\$1,200).....	4,600
4. Infant welfare, school, and tuberculosis clinic maintenance.....	1,500
Grand Total.....	<u>\$12,600</u>

B. Private Agencies (Industry)

1. Three industrial physicians.....	\$7,500
2. Six industrial nurses.....	7,000
3. Industrial and general medical clinic maintenance.....	3,500
Grand Total.....	<u>\$18,000</u>

IMMIGRANT HEALTH AND COMMUNITY

It must be realized that this cost will cover other activities not itemized in the above list and that very substantial financial returns may be expected from certain of the services. Further, aside from financial returns, the industrial work more than compensates the industries in the conservation of labor, the efficiency of employees, etc.

The fact that many essentials of this plan are already in operation in Framingham, adds to its value.

To put these principles into practice all over the vast extent of the United States, with its several thousand small communities, is an enormous undertaking. The Framingham experiment as yet stands practically alone as the one carefully considered effort to deal with the problem, and it is still in its earlier stages. We need at once similar experiments in other communities of different types. We need constant comparison and analysis of methods and results, so as to develop fully the principles on which the methods have been based, the extent to which different principles have been successful, the reason for their success or their failure, and the bearing of all this upon national and local programs of medical and health service.

XIX

NATIONAL APPLICATIONS

THE beginning of Americanization is with Americans. The beginning of effective medical health work among immigrants depends on the right point of view among American health officers and health workers—a point of view which is sympathetic, democratic, and based on understanding of the people with whom the health worker is dealing.

Knowledge of immigrant backgrounds and characteristics is the right foundation for this point of view, and for successful work with and for the immigrant. Some knowledge of the language, even a few words, is most useful to the field worker. But knowledge of backgrounds and characteristics is even more important because it gives the ability to utilize interpreters, foreign-language literature, and personal contacts, with real effectiveness.

TASKS FOR NATIONAL AND LOCAL ORGANIZATIONS

For the development of technique with the foreign born in the various practical measures which have been outlined, it is desirable that there be committees or bureaus of national organizations to fulfill the following functions:

- (a) Collation and publication of the methods and

IMMIGRANT HEALTH AND COMMUNITY

results of local organizations in medical and health work with the foreign born. This same body could serve to instigate and co-ordinate studies in the vital statistics of the foreign born.

(b) Stimulation, development, and standardization of the education of field workers for effective service among the foreign born.

(c) Practical assistance to local organizations in the development of medical and health service for their immigrant population. This will be particularly valuable during the next few years, when all experiments along this line will be profitable to other communities.

There is a tendency in America for every new idea to call forth a new organization. The development of better medical and health work for the foreign born in this country is not a new idea, but, as this survey has shown, special attention to the foreign born is not yet characteristic of American medical and health agencies. Much must be done to put into practice by the many the ideas, the ideals, and the methods which have already been conceived or tested out by the few. Yet this advance ought not to require a new organization. There are already in existence a host of national societies, local associations, and governmental agencies performing medical or health work, training medical or health workers, carrying on research, or devoting themselves to publicity and popular health education.

The chief organizations carrying on curative medical work are the hospitals and the dispensaries. Some of these are organized locally, and the whole body have their national organization, the American Hospital Association. The visiting nurses and the medical social workers of the country are each nationally

NATIONAL APPLICATIONS

organized. So are the dietitians. In the field of preventive medicine the health departments and the militant health agencies have several national and many state organizations. Chief among these is the American Public Health Association. The aim is to make each of these organizations perceive that the successful accomplishment of its purpose requires more attention to the special problems of the foreign born and to the special methods necessary for greatest efficiency in work among them.

Considering the already bewildering multiplicity of medical and health organizations in the United States, it is unwise to establish a new organization if it can be avoided. The study of the problems of health and disease among the foreign born, and of better methods for their solution, ought rather to be undertaken by special sections or committees, or specially appointed executives, of existing organizations.

National and state organizations do not, as a rule, undertake much detail work in the field, but confine their efforts to research, publicity, or advisory service. Such bodies sometimes subsidize local organizations for a piece of research or of experimental field work. Further comparison of the morbidity and mortality statistics for native and foreign born, and for different race groups, is one of the fundamental and constructive tasks ahead. All local, state, and national organizations having anything to do with medical or health work, have a direct interest in such investigations. Among the organizations which have already collected statistics on this subject, or have pursued special investigations, are the United States Census Bureau, life-insurance companies, local and state departments

IMMIGRANT HEALTH AND COMMUNITY

of health, and local voluntary medical and health agencies. Sporadic investigations of this type need both encouragement and co-ordination.

NEED FOR A CENTRAL STANDARDIZING AGENCY

It would be well for some national body, representative of these various organizations, to serve as a central stimulative and advisory agent—helping to standardize technique so that the results of different studies should be comparable, suggesting new problems or questions on which research is needed, and collating, publishing, or stimulating the publication of co-ordinated results and surveys.

A Committee or Bureau on Health Work with the Foreign Born, of a representative national body properly financed, would fulfill a highly important national function, not only in stimulating statistical research, but also in collating and advancing methods of health education and field work among the foreign born, and in disseminating whatever knowledge and advice such activities would yield.

TRAINING HEALTH WORKERS

The training of health workers for successful service among the foreign born is another major task. Among the organizations now chiefly concerned with such training are the schools for health officers, the nurses' training schools, particularly those schools offering special courses in public-health nursing, and the special schools or college departments which are training men and women for social service. The most numer-

NATIONAL APPLICATIONS

ous body of workers actually engaged in the application of medical and health service to the foreign born are, and will remain for an indefinite period, the visiting nurses.

The development of better educational methods, and the study and advancement of better technique in field work among the foreign born, would seem a subject particularly appropriate for the National Organization for Public Health Nursing. The several thousand local visiting-nursing associations throughout the country, large and small, are experiment stations in methods of field work, and include a considerable number of centers in which public-health nurses are trained. In this, as in other phases of health work, experience with the foreign born is accumulating.

In order, however, to make this phase of experience valuable, it must be continuously watched and periodically surveyed and collated. *A special secretariat on work with the foreign born*, if connected with a body like the National Organization for Public Health Nursing, would be a highly important contribution to the technique of medical and health work throughout the United States and to the education of new workers.

A CLEARING HOUSE FOR INFORMATION AND METHODS

It is much to be hoped that various special problems touched upon in the course of this volume may be taken up by appropriate national bodies. For example, hospital and institutional dietaries must be adapted to the needs of immigrant patients; dietitians, nurses, and social workers can also help to adapt

IMMIGRANT HEALTH AND COMMUNITY

budgets to needs and tastes in immigrant families. Departments of dietetics or home economics in colleges and universities ought to devote more attention to this subject, and the American Dietetic Association, through its conventions and its committee work, should pursue it systematically.

The important service which the American Medical Association has rendered in enlightening the medical profession and the public about the quack, has been limited thus far to the relations of the quack and of undesirable proprietary medicines to the English-speaking population. It is to be hoped that this association will devote attention to the situation in the foreign-language field and to the conditions of quack practice among the foreign born.

The more discriminating and effective use of health literature especially prepared for the foreign born, the preparation of exhibits and other educational measures for them, falls necessarily within the field work of local militant health agencies. But a great economy and a gain in efficiency would be brought about if national bodies gave the expert service which is rarely available to local organizations. The life-insurance companies could render notable service in this field to many health organizations as well as to some of their own industrial policy holders. Such a committee of a representative national body as has already been suggested, could serve as a bureau for the collection and collation of methods, the expert preparation and translation of literature and posters, rendering the best accessible to all, and stimulating the development of still better.

Such an organization as the American Hospital As-

NATIONAL APPLICATIONS

sociation, or perhaps the newly formed American Conference on Hospital Service, would seem naturally to have for its field the humanization and improvement of methods for adapting hospital and dispensary service to the needs of immigrant patients. Any one of the specialized militant health agencies, such as the National Tuberculosis Association or the American Social Hygiene Association, could take up special investigation, advisory or experimental field work, to improve its policies and methods among the foreign born. The United States Public Health Service and governmental agencies in the states might take an advanced position in this matter through a special bureau or detail of officers. But most of the activities required in the immediate future demand a freedom and camaraderie which call for the private voluntary organization.

STIMULATION OF LOCAL ORGANIZATION

There remains a third need which no one of these organizations can fulfill—namely, to encourage and assist local organizations to devote themselves more effectively to medical and health work among the foreign born. The postwar program of the American Red Cross is largely a health movement. In the foreground, as thus far announced, stands the stimulation of health centers throughout the United States. This activity of the Red Cross, according to the preliminary utterances of its officers, has particular application to smaller communities, and is to be democratically conducted by a stimulative and advisory, instead of a centralized method of government.

IMMIGRANT HEALTH AND COMMUNITY

As has already been pointed out, a large part of the health center work thus far undertaken has been in districts or communities largely populated by the foreign born; in fact, such a situation is inevitable, if health centers are to be established in sections of cities or in smaller communities where the need is greatest. The health center will be a name covering many different types of work, sometimes ranging outside of the medical and health field, but medical and health work will always be included in the activities of such centers. In any case, successful results will in a large proportion of localities depend upon the ability of those conducting the work to deal with the problems and personalities of foreign-born Americans.

The health-center program of the Red Cross will be of increased assistance to the local organizations of the Red Cross and to other local bodies which will actually conduct the health centers, if the national or division organization of the Red Cross gives special advice and aid in the health problems of the foreign born and the best ways of meeting them. Such assistance should be rendered largely through an expert advisory staff, which will be subject to the call of local chapters or any appropriate local organization—a staff familiar with the backgrounds and characteristics of different immigrant groups, with their problems and the policies and methods of dealing with them.

It might be desirable in some instances if the Red Cross financed organizations selected to work out certain typical medical and health problems with the foreign born, particularly if the results and methods which achieved them could be recorded, written up, and published so as to be accessible for all.

NATIONAL APPLICATIONS

If such national organizations as the American Public Health Association, the National Organization for Public Health Nursing, and the American Red Cross, will take part in the advancement of our knowledge concerning the health problems of the foreign born and in the practical development and application of better methods for solving these problems, we may hope for rapid and continuous advancement in the application of existing scientific knowledge to secure far-reaching human results.

HEALTH WORK AND NATIONAL STAMINA

Is medical and health work a desirable agent of natural selection? By the refinement of methods for the detection and cure of disease, by the promotion of measures which sustain health and prolong life, do we bolster up the weak, aid them to propagate their kind, and lower the future physiological stamina of our people? Has the improvement of methods of medical and health work among the foreign born in this country anything to do with such an undesirable natural selection, if it exists?

Behind these questions lie the fears and prejudices of many. Let us try to approach them without either prejudice or fear.

The influence of immigration on the physical characteristics of the people of the United States is a subject upon which no adequate body of definite information exists. Decennial censuses give us cross sections and race constitution after a fashion, but they tell us little, and as the children of immigrants grow up, marry, and have children, these members of the third generation are native born, of native parents,

IMMIGRANT HEALTH AND COMMUNITY

and pass out of the census tables, so far as any racial analysis is concerned.

For instance, we have almost no information on such a fundamental question as—how rapidly is amalgamation by marriage proceeding between native born and foreign born? What race groups tend most rapidly to amalgamate thus? What are the effects of such unions upon the physical, mental, and moral characteristics of the children? Opinions can be found without number on this subject of amalgamation, born of race pride or race prejudice, or of religious or local divisions. These take us nowhere. We must have facts if we are to reach conclusions.

NO INHERENT RACIAL SUPERIORITY

In the absence of facts the only conclusions which we should reach is that well expressed by Prof. Franz Boas in his notable book *The Mind of Primitive Man*. He holds up to daylight the prevalent assumption of ¹

. . . the existence of gifted races and of others less favorably endowed, and (we have) found that it was based essentially on the assumption that higher achievement is necessarily associated with higher mental faculty, and therefore the features of those races that in our judgment have accomplished most are characteristics of mental superiority. We subjected these assumptions to a critical study and discovered little evidence to support them. So many other causes were found to influence the progress of civilization, accelerating or retarding it, and similar processes were active in so many different races that, on the whole, hereditary traits, more particularly hereditary higher gifts, were at best a possible, but not a necessary, element determining the degree of advancement of a race.

I hope the discussions contained in these pages have

¹ Franz Boas, *The Mind of Primitive Man*, pp. 244-278.

NATIONAL APPLICATIONS

shown that the data of anthropology teach us a greater tolerance of forms of civilization different from our own, and that we should learn to look upon foreign races with greater sympathy, and with the conviction that, as all races have contributed in the past to cultural progress in one way or another, so they will be capable of advancing the interests of mankind, if we are only willing to give them a fair opportunity.

RELATIVE BIRTH RATE UNIMPORTANT

Some facts exist on the relative rate of propagation of different race groups in the United States. We are periodically shaken and shocked by reports that the American native stock is dying out, that the Poles or the Jews or the Italians or other races of immigrants are having so many children per mother that they, and not the Anglo-Saxons, shall inherit this fair American earth.

A few such statistics have been quoted indicating the apparently high fecundity of foreign-born women. But it was pointed out that unless the age classification of native and foreign women of different races is standardized, we are likely to be led into error. If a group of foreign-born married women happen to average even a few years younger than do the American-born married women of the same community or other area, the number of children per mother would be certainly greater among the foreign-born women than the native. Yet this difference would be due to the fact that the foreign-born women had chiefly come to this country during the early years of the childbearing period, and did not represent as large a number of women at the older childbearing ages as a normal population does.

IMMIGRANT HEALTH AND COMMUNITY

The difference between a greater physiological fertility of the foreign-born women and the actual number of children per mother is a difference of great importance, and would appear in the next generation. On this subject we have as yet practically no information. Meanwhile let us not hasten to conclusions as to what race will inherit the American earth.

The differences in death rate are no less significant than those of birth rate. We have seen that the death rate of the foreign born, in spite of more favorable age distribution, is on the average distinctly higher than that of the natives. We have seen that the infant death rate of several foreign-born groups concerning whom the fears and prejudices of some native Americans have been especially roused is particularly high; sometimes double, sometimes treble or more than treble that of the native born in the same community. We need much further study to determine how far the higher infant death rate among the foreign-born groups is equating their higher birth rate to the net birth rate of the native born. Since the foreign born are apparently subject to a higher death rate during childhood and also through adult life, the same study would have to be pursued to later age periods than infancy in order to reach a conclusion as to the net result.

The descendant of the *Mayflower* reads, perhaps, with a mingling of awe and pride of the families of twelve to twenty-four children, so prevalent in the days of Cotton Mather. Those families, he learns, often succeeded in killing several mothers before they were completed. Such large families were the natural reaction of a vigorous people to a new country in which children were an asset, and in which conditions

NATIONAL APPLICATIONS

of life were more favorable in many respects than those which they had left abroad. The native Indians of New England at the time of Cotton Mather, the *real* Americans of that day, apparently had small families. The descendant of the *Mayflower* now sees history repeating itself. The immigrants, recently come to a more favored country than their native land, are having larger families than those who have been here longer and who have accepted certain standards which tend to reduce the number of children in a family.

There is not a little evidence that some sections of the native white American stock are having not only much smaller families than the foreign stock, but families so small that the stock will not keep up its numbers in the next generation. But we have no physiological or sociological evidence to prove that this in itself is an evil, even if it be generally true among the native born, or that the relatively greater fertility of recent immigrants is an evil or is likely to be permanent, whether it is evil or good.

We may be fairly sure of one point—that the psychological process of Americanization proceeds so much more rapidly, at least after the first generation, than any biological process of natural selection can possibly proceed, that whatever changes take place in the characteristics of our population within a period of fifty to a hundred years will be determined much more by psychological and sociological than by biological factors. The rate of social and spiritual fusion of native-born and foreign-born elements in America is probably the ultimate determinant of the more important conditions affecting the rates of net in-

IMMIGRANT HEALTH AND COMMUNITY

crease for races of different origins. In so far as economic status and standards of living influence birth and death rates, the governing influences are psychological and social.

Again we lack facts concerning the effects of amalgamation. Dr. Charles B. Davenport has pointed out some of the possible physical consequences of amalgamating different races.¹

If one parent belong to a tall race—like the Scotch or some of the Irish—and the other to a short race, like the South Italians, then all the progeny will tend to be intermediate in stature. If two such intermediates intermarry, then very short, short, medium, tall, and very tall offspring may result in proportions that cannot be precisely given, but about which one can say that the mediums are the commonest and the more extreme classes are less frequent, the more they depart from mediocrity. In this case of stature we do not have to do with merely one factor as in eye color, or two as in negro skin color, but probably many. That is why all statures seem to form a continuous curve of frequency with only one modal point, that of the median class.

But I am aware that I have not yet considered the main problem of the consequence of race intermixture, considering races as differing by a number of characters. First, I have to say that this subject has not been sufficiently investigated; but we may, by inference from studies that have been made, draw certain conclusions. Any well-established abundant race is probably well adjusted to its conditions and its parts and functions are harmoniously adjusted. Take the case of the Leghorn hen. Its function is to lay eggs all the year through and never to waste time in becoming broody. The brooding instinct is, indeed, absent; and for egg farms and those in which incubators are used such birds are the best type. The Brahma fowl, on the other hand, is only a fair layer; it becomes broody

¹ C. B. Davenport, *The Effects of Race Intermingling*, pp. 365-366.

NATIONAL APPLICATIONS

two or three times a year and makes an excellent mother. It is well adapted for farms which have no incubators or artificial brooders. Now I have crossed these two races; the progeny were intermediate in size. The hens laid fairly well for a time and then became broody and in time hatched some chicks. For a day or two they mothered the chicks, and then began to roost at night in the trees and in a few days began to lay again, while the chicks perished at night of cold and neglect. The hybrid was a failure both as egg layer and as a brooder of chicks. The instincts and functions of the hybrids were not harmoniously adjusted to each other.

Turning to man, we have races of large, tall men, like the Scotch, which are long lived and whose internal organs are well adapted to care for the large frames. In the south Italians, on the other hand, we have small, short bodies, but these, too, have well-adjusted viscera. But the hybrids of these or similar two races may be expected to yield, in the second generation, besides the parental types, also children with large frame and inadequate viscera—children of whom it is said every inch over 5' 10" is an inch of danger, children of insufficient circulation. On the other hand, there may appear children of short stature with too large circulatory apparatus. Despite the great capacity that the body has for self-adjustment, it fails to overcome the bad hereditary combinations.

Again it seems probable, as dentists with whom I have spoken on the subject agree, that many cases of overcrowding or wide separation of teeth are due to a lack of harmony between size of jaw and size of teeth—probably due to a union of a large-jawed, large-toothed race and a small-jawed, small-toothed race. Nothing is more striking than the regular dental arcades commonly seen in the skulls of inbred native races and the irregular dentations of many children of the tremendously hybridized Americans.

MODERN FITNESS DEFINED

From these excursions into the desert of surmise we may return to our original question as to the effects

IMMIGRANT HEALTH AND COMMUNITY

of medical and health work upon different race groups within the United States, and the resulting net quality of our population. Does the improvement of methods of medical care tend toward keeping alive the unfit? Does the wider application of better methods of medical care to larger groups of the population tend to keep alive many of the weak and undeveloped, who can be little more than a burden upon themselves and the community? Does success in the prevention of disease tend in the same direction?

“Fitness” is a relative term. Fitness for modern life is not the same as for the life of the cave man, the mediæval knight, or his manorial peasant. The happiest and most efficient living demands a sound body. But success in modern life and fitness for success in it depend primarily upon a good sound mind. Many of the chief epidemic diseases to which the civilized portions of the human race are now subject appear to exercise very little selection of the physically weak over the physically strong. Some diseases appear to strike the strong rather than the weak. One outstanding and important truth has come forth as the result of modern preventive medicine—namely, that under conditions of modern civilized life the maintenance of bodily health depends on intelligence and self-control more than on anything else.

NATURAL SELECTION PROMOTED

Successful results in the cure of disease when it has come upon individuals depend to a considerable degree upon the intelligence and co-operation of the patient, or of the patient's parents if the sick person be a child. Success in preventing disease depends

NATIONAL APPLICATIONS

almost entirely upon the intelligence and the power of self-control of the individual and the group in which he lives. The tendency of properly directed efforts toward the cure and the prevention of disease is toward the preservation of those elements of our population which are capable of intelligent response, and of physical and moral self-control.

Stupid mothers may have babies, but mothers who will not learn how to take care of their babies will lose them. Syphilis and gonorrhea are probably the greatest single causes of the failure of individuals to reproduce their kind. The ultimate success of prophylaxis of syphilis and gonorrhea rests upon the ability of individuals to understand what these diseases are and to live such lives as will avoid incurring them. Those who cannot learn, or who have not the stuff in them to practice what they learn, will suffer. Others, indeed, may suffer innocently, but in the main the proposition stands. The curative measures which stand in the forefront of the practical campaign against syphilis and gonorrhea depend for their success largely upon the intelligent co-operation of the patients; and perhaps the most far-reaching value of these curative resources, such as clinics, is the opportunity they give for effective education of individuals and families in the nature, the dangers, and the prevention of venereal diseases.

Better medical and health work among the foreign born is not, according to these principles, a measure which promotes the survival of the unfit, but a means of prolonging the life and promoting the efficiency of those who have the intelligence and capability to respond to the opportunities offered. Well-conceived

IMMIGRANT HEALTH AND COMMUNITY

measures to provide medical facilities for the care of disease, and educational and other measures for its prevention, tend to select population on the basis of intellectual and moral quality more than they tend to perpetuate the weak and the unfit.

THE DEMOCRATIC PROCESS

This is true at least when there is no barrier of conviction or prejudice between those who are offering curative and preventive services and those to whom they are offered. If American methods of medical and health work are such as to provoke and maintain prejudice and opposition among the foreign born, then the value of our preventive measures particularly is reduced to a minimum, and our curative facilities attract only the weak and incapable members of their group—who do not share their group spirit enough to stand with their own people.

The great danger to medical and health work with the foreign born is that wrong relations may be established between the native Americans and the immigrants; that the native Americans may proceed with a theory of offering charity, or with a set of prejudices in the back of their minds, or with a smile of contempt, even when they are offering help. The only possible reaction of any self-respecting foreign group to such policies and methods is to meet prejudice and antagonism with prejudice and contempt. In these circumstances, even when actual services are accepted in time of bitter need, mutual understanding and co-operation will not develop.

Measures for medical and health work among the

NATIONAL APPLICATIONS

foreign born, conceived and carried out in a co-operative and democratic spirit, adapting American policies and points of view to immigrant backgrounds and characteristics, are helpful agents in the selection of the most desirable elements of each race group as participants in American life. The duty of America is to regard the promotion of health as at least as fundamental as the promotion of education. America ought to provide facilities for the care of illness and for the prevention of disease according to the best standards known to science, and to render these facilities accessible to all on terms they will understand, so that they will use them when they need them.

Co-operation between those who render the service and those who receive it is the only policy compatible with democracy. Health is one of the inclusive and continuing interests of life, beginning when the mother first feels the stir of the coming child, and ending only with the last breath. Americanization is the effort of a great multitudinous population toward the creation of a united, harmonious, self-determining people. Co-operation of all elements of our population in a common effort toward happier and more efficient living must include mutual endeavors toward realizing the best in physical well-being, as well as the best in economic conditions, political organization, and cultural activities.

Such an effort requires participation by all race groups in the acquirement of the knowledge that science gives of the laws of life, the nature of disease, and the practical arts of hygiene. Organization to promote such co-operative effort for health is part of

IMMIGRANT HEALTH AND COMMUNITY

the task of any community, and will create a truly American democracy and not a stratified or segregated community of different races. The inclusion of medical and health work in the program of Americanization is not only the task of the physician and the professional administrator, but of the teacher and the statesman.

APPENDIX

RECIPES OF THE FOREIGN BORN

THE ITALIANS

The following are prescribed for undernourished children:

1. Zuppa alla Provinciale (Potato Soup)

2 large potatoes	2 tablespoonfuls butter
3 tablespoonfuls milk	2 egg yolks
4 cupfuls soup stock	

Boil potatoes; rub through sieve. Put in saucepan with butter, salt, and milk. Simmer until thick, then add egg yolks to form it into a paste. Turn on to bread board, cut into small dice, and throw into the soup stock, which must be boiling.

2. Zuppa di Lattuga (Lettuce Soup)

1 head lettuce	2 tablespoonfuls green peas
2 potatoes	1 heaping tablespoonful
1 head of celery	flour
4 cupfuls soup stock	

Cook all together for one hour and a half and serve with toasted squares of bread.

3. Zuppa di Zucca (Pumpkin Soup)

3 pounds sliced pumpkin	$\frac{1}{2}$ cupful water
2 tablespoonfuls butter	$1\frac{1}{2}$ cupfuls milk
1 tablespoonful sugar	

Peel pumpkin, cut into pieces, cook in water with butter, sugar, and salt for two hours. Drain and add to milk which has been heated. Bring to a boil before serving.

IMMIGRANT HEALTH AND COMMUNITY

4. Brodo di Lenticchie (Lentil Soup)

3 tablespoonfuls dried lentils 2 tablespoonfuls milk
4 cupfuls soup stock
½ tablespoonful butter

Cover lentils with water and simmer until soft; put through sieve. Melt butter in saucepan, add lentils and milk; mix well. Add a cupful of stock, and this to three cupfuls of hot stock.

Some of the Italian soups more nearly resembling our own are *minestrone alla Milanese* or vegetable chowder, *brodo di capone*, or chicken soup, and *brodo di carne*, or vegetable and beef soup. Milk soups are rarely used by the Italians.

Milk may be given plain or in custards, as in *gnocchi* of milk or in *zabione*.

5. Gnocchi of Milk

1 cupful milk 3 drops vanilla
1 level tablespoonful corn- 2 egg yolks
starch 2 tablespoonfuls sugar

Put all these ingredients together in saucepan, mix well, then put on stove and let cook slowly until thick. When cold serve with milk or cream.

6. Zabione

2 cupfuls milk 4 drops vanilla
½ cupful sugar 2 eggs

Put all together in saucepan and beat well. Put on back of stove; let it heat and cook slowly, stirring often until thick. Serve hot or cold.

Other recipes which may be used for children are as follows:

7. Spinagi

½ peck spinach ½ tablespoonful butter
1 tablespoonful salt ½ tablespoonful flour
5 tablespoonfuls cream 1 egg yolk
3 egg whites

Wash and cook spinach in salt and one tablespoonful of water for twenty minutes; chop fine. Put butter and flour in saucepan. Stir while heating, then add chopped spinach.

APPENDIX

Cook for five minutes and add cream. Add well-beaten yolk of egg; when cool add well-beaten whites, then place mixture in a buttered baking dish and bake for ten or fifteen minutes. Italian-cooked vegetables are best for children in this form.

8. Lattuga Informata (Lettuce Baked in Oven)

Take off wilted outside leaves, tie up heads and place in baking pan with two cupfuls of soup stock. Bake one half hour. Place fork under heads, remove, and serve with stock for gravy.

9. Polenta (Corn Meal Mush)

This is usually eaten with meat gravy instead of milk. It would not be a difficult task to teach children to eat it with milk.

10. Gnocchi di Semolina (Indian Meal)

Often called farina by the Italians. Cooked in milk.

11. Canestrelli (Tea Cakes or Cookies)

$\frac{1}{2}$ cupful sugar
 $\frac{1}{2}$ cupful flour

1 egg yolk
 $\frac{1}{2}$ teaspoonful vanilla

Cream together sugar and butter; add well-beaten egg yolk and vanilla; then enough flour to make a firm, smooth dough. Roll out thin and cut into fancy shapes.

THE JEWS

Prohibited Foods

Prohibition of Animal Foods.—Absolute and partial prohibitions:

Unclean animals are absolutely prohibited. Clean animals are all quadrupeds that chew the cud and also divide the hoof. All others are regarded as not clean.

Products of animals that are suffering from some malady or that have died a natural death or had eaten poison are regarded as *terefah* and may not be used.

All animal food which is not obtained by killing in the *prescribed manner* and after adequate inspection by a duly authorized official may not be used.

IMMIGRANT HEALTH AND COMMUNITY

Blood was regarded by the ancient Hebrews, and is by many primitive peoples to-day, as the vital part of the animal which must be given back to God. Fish does not come under this category, possibly because it is a cold-blooded animal.

"Fish that have fins and scales—none other—may be eaten." This would bar all shellfish, such as oysters and lobsters, as well as fish of the eel variety. There seems to have been some good dietetic reason for this, as the Eastern waters were doubtless often polluted, and there may have been cases of poisoning, resulting from mistaking poisonous water snakes for eels.

No scavengers or birds of prey are to be eaten. These are regarded as unclean.

The suet of ox, sheep, or goat is forbidden (not the fat). Fat of birds or permitted wild animals is not forbidden.

An egg yolk with a drop of blood on it is considered as an embryo chick and is forbidden.

Prescribed Modes of Preparing Food

The following partial prohibitions are fully as important as the above:

After the proper cut of meat is secured from the proper kind of animal which has been slaughtered in accordance with Jewish law, it is to be soaked half an hour to soften the fiber and enable the juice to escape more readily when salted. (The pan used for this purpose may not be used for anything else.) The meat is then thoroughly salted, placed on a board which is either perforated or fluted, and placed in an oblique position so as to enable the blood to drain off. It is allowed to remain thus for one hour, after which time it is to be washed three times. The washing is for the purpose of removing all the salt. This process is called *leashern*, and is regarded as very important.

Bones with no meat and fat adhering to them must be soaked separately and during the salting should not be placed near the meat.

Chops and steaks may be broiled.

The heart may be used, but must be cut open lengthwise

APPENDIX

and the tip removed before soaking. This enables the blood to flow out more freely. Lungs are treated as is the heart. Milt must have veins removed. The head and feet may be *kashered* with the hair or skin adhering to them. The head must have the brain removed. This latter, if used, must be *kashered* separately.

To *kasher* fat for clarifying, remove the skin and proceed as with meat.

In preparing poultry it must be drawn and the insides removed before putting into the water. The claws must be cut off before *kashering*. The head must be cut off. The skin of the neck must be either turned back or cut so that the vein lying between two tendons may be removed.

Seething a kid in its mother's milk is forbidden.

This is the origin of the prohibition against the cooking of meat and milk together or of the eating of such mixtures. This rule is rigidly adhered to and in its present application necessitates the use of a complete double equipment of dishes and utensils. Since this rule is regarded as one of the most important, one can understand why such sauces as butter sauces are refused at meals with meat. This rule occasions the home economics teacher considerable trouble in planning menus.

Meat and fish should not be cooked or eaten together, for such a mixture is supposed to cause leprosy. The mouth has to be washed after eating fish and before meat may be eaten.

In addition to the above regular daily restrictions there are the periodic restrictions that the teacher should know.

Jewish Holidays

Sabbath.—No food may be cooked on the Sabbath. This means that all cooking for both days is done on Friday. This need has led to the development of foods such as Sabbath *kugel* or *sholend*, *petshai*, and many others.

Passover.—During Passover week no leavened bread or its product, or anything which may have touched leavened bread, may be used. This restriction holds for eight days. In every Jewish home a complete and most thorough system

IMMIGRANT HEALTH AND COMMUNITY

of cleaning precedes this holiday. No corner escapes a scrubbing and scouring, lest a particle of leaven or, what is just as bad, a particle of food which may have touched leavened bread, should be found. A complete new set of dishes is used during the week. Cutlery, silver, or metal pots may be used during this holiday if properly *kashered* or sterilized. The usual method of doing this is to plunge red-hot coals into boiling water and then to immerse the desired utensils. These or any other Passover utensils may be used after the holiday is over without re-*kashering*, but once used without Passover precautions they are unfit for Passover use unless re-*kashered*. In actual practice this means that in every orthodox Jewish household there are four sets of dishes—the usual set for meat and the set for milk food, in addition to duplicate Passover sets. The Passover dishes are stored away very carefully lest some leaven come near them.

Because of the need for abstaining from leavened bread during Passover many interesting dishes have developed, such as the *mazzah klos* (dumplings) soup, cakes, and puddings made of the *mazzah* meal. Almond pudding and cake are very popular. Almost all of the food cooked during this holiday requires the liberal use of shortening or fat, with great danger of a too liberal use for health, as well as from the economic point of view. The fat generally used is either goose or chicken dripping or clarified beef fat other than suet.

Fast Days.—(a) Yom Kippur (The Day of Atonement). No food or drink may be had for twenty-four hours. (b) Fast of Esther. This precedes the Feast of Purim and is now observed only by the very pious. The feast is universally observed.

Semifast Days.—Eight days in Ab. For nine days no meat food may be eaten by the orthodox.

Characteristic Jewish Dishes

From Spain and Portugal comes the fondness of the modern Jew for olives and the use of oil as a frying medium. The sour and sweet stewing of meats and vegetables comes

APPENDIX

from Germany. The love of pickles, cucumbers, and herrings comes from Holland, as also does the fondness for butter cakes and *bolas* (grain rolls). From Poland the Jewish immigrant has brought the knowledge of the use of *lokschen* or *fremsel* soup (cooked with goose drippings), also stuffed and stewed fish of various kinds. From Russia comes *kasha*, made of barley or grits or cereal of some sort, which is eaten instead of a vegetable, with meat gravy.

Blintzes are turnovers made of poured batter and filled with preserves, or cheese, and used as a dessert. *Sholent*, sometimes called *kugel*, are puddings of many kinds, such as *magan*, *lokschen*, *farfil*. *Zimes*, or compotes of plums, prunes, carrots, and sweet potatoes, turnips and prunes, parsnips and prunes, and prunes and onions, are all puddings, and come from Russia. *Zimes* of apples, pears, figs, and prunes are southern Rumania, Galician, and Lithuanian as well.

Soups are the great standby of the poor. *Krupnick* is a term used for cereal soups made of a cereal like oatmeal, with potatoes and fat. When the family can afford it, meat or milk is added, as the case may be. This is the staple food of the *yesbit* (schools to which Jewish boys are sent to be instructed in Rabbinical lore). When there is neither meat nor milk in the soup it is called *soupr mit nisht*. This is really *supper mit nichts*.

Borsch is a form of soup. It is made of either cabbage or beet root and *rassel* (juice derived from the beet). This is made by the addition of meat, bones, onions, raisins, citric acid, sugar, and sometimes tomatoes. Eggs are added just before serving to whiten it. This is called *farweissen*.

Gehakte herring is really a salad made of chopped boned herring, with hard-cooked eggs, onions, apples, pepper, and a little vinegar and sugar. It is used as an appetizer in the form of a canape.

Sabbath *kugel* or *sholent* is a dish of meat, peas, and beans, sometimes barley or potatoes as well, which is placed in the oven before Sabbath and which is usually eaten hot on the Sabbath. This dish is sometimes also called a *shalet*.

IMMIGRANT HEALTH AND COMMUNITY

Petshai or *drelies*, characteristic of south Russia, Galicia, and Rumania, is a calves' foot jelly made at home. (Commercial gelatin is prohibited.) The calves' feet are cleaned by first singeing off the hair. They are then *kashered* and stewed with onions and seasonings of salt and pepper. Like the Sabbath *kugel*, this is placed in the oven the day before and is ready hot by Sabbath noon. What is left is freed from bone, has hard-cooked eggs and vinegar added, and is allowed to congeal. This forms a sort of aspic which is served cold in the later afternoon.

Strudel, taken from the Germans, is a single-layered jelly or fruit cake and takes the place of pie as a dessert. It is usually rolled. The dough is as thin as tissue paper.

Teigachz is a pudding sometimes called *kugel* or *sholend*, and may be made of rice, noodles, or even mashed potatoes. These usually have some drippings, eggs, and flavoring added.

Gebrattens is pot roast and is usually accompanied by *kasha*, though it is often served with potatoes which have been cooked with the pot roast. These are really stewed to a golden brown. Onions are always an important ingredient.

Almond pudding is a favorite because it requires neither meat nor butter and can therefore be eaten at either type of meal. It is made of almonds, eggs, sugar, cinnamon, and lemon rind, and baked.

The obstacles to the use of meat have developed a taste for fish, as well as for cheese and milk products. Since fish is not a warm-blooded animal, it may be eaten in conjunction with milk and milk products. (This is an added reason for its popularity. The celebration of the Sabbath and the eating of fish have always been associated.) Mrs. Schapiro declares that "from no orthodox table is fish absent at one or more of the Sabbath meals, however difficult it may be to procure. In inland countries like Poland the Jews are limited to fresh-water fish. I have known people, who could barely afford bread during the week, to pay as much as forty or even fifty cents per pound for their Sabbath fish. Salmon is a favorite kind of fish.

APPENDIX

This is fried, white stewed, or brown stewed. Smoked salmon, pickled herrings, and pickled pickerels are served as appetizers by the Russian Jews. Most characteristic of all the fish dishes, perhaps, is the *gefilte fish*, for which carp, whitefish, and pike are most generally used. Part of the flesh of the fish is removed and chopped with onions, bread crumbs, seasonings, and egg. The mixture is returned to the fish, which is then cooked or stewed with more onions and a large amount of pepper for several hours at a low temperature. The long, slow cooking develops the flavor of the different kinds of fish, which blend and form a most palatable dish. While Jewish fish dishes form excellent appetizers, or even entrées, I do not think they are desirable as the main dish of the meal, because of the high seasoning. For this reason they are particularly bad for children. . . .

12. Krupnick

1 cupful rolled oats	1 tablespoonful goose or
3 cupfuls milk	chicken fat
6 potatoes cut up	

Boil all together three hours.

13. Borsch (Russian Beet Soup)

To have a good, wholesome *borsch* with a natural sourness you have to make what is known as *rassel*. Take three bunches red beets, peel and cut in halves, wash. Put into a wooden or earthenware jar. Cover with tepid soft water and set in a warm place, covering jar with towel. In four days *rassel* will be ready. A crust of real dark bread improves *rassel*. When *rassel* is ready put it into a cellar or other cool place to prevent the process of fermentation from continuing. To make *borsch*, make a good consommé with meat and as many vegetables as are on hand. When consommé is ready, bake a few raw beets in skins; when ready cut them fine and sprinkle with a little sugar. Add to strained consommé and add some of the *rassel* to taste. Boil once and serve with sour cream.

14. Almond Omelet

½ cupful almonds	4 eggs
4 tablespoonfuls cream	

IMMIGRANT HEALTH AND COMMUNITY

Blanch the almonds, chop fine, and pound smooth. Beat the eggs, add the cream, and turn into a hot pan in which one tablespoonful of butter has been melted. When the omelet is set, sprinkle the almonds over it, fold over, and serve.

15. Bitki (Hamburg Steak)

Take two cupfuls of clear beef chopped and two cupfuls of bread crumbs that have been soaked in a little water, leaving them quite moist; mix thoroughly, season with pepper and salt, and shape into individual cakes. Fry as Hamburg steak.

Both *kascha* and *schavel* are dishes that can be recommended and enjoyed. They are made in the following way:

16. Kascha

Made of whole buckwheat grain or fine barley or whole oats or millet (to be washed in many waters before using). Take one pound of grain and rub through it one whole egg. Dry thoroughly on a frying pan, stirring to prevent burning. When dry put into an earthenware dish with cover. Cover with boiling water. Add salt to taste and butter size of egg. Bake in moderate oven until done (from two to three hours). Watch to prevent burning. When edges get too dry add boiling water, pouring along edges. Favorite dish for peasant.

17. Schavel (Sorrel Soup)

Chop fine one pound sorrel, one pound spinach, put in a pot and cook in boiling water (open pot), adding salt to taste. When greens are tender, in about one half hour, take two yolks of eggs in a bowl, rub with a little salt, and stir hot mixture into the yolks drop by drop to prevent curdling of yolks. Set out to cool. When cold put on ice. To serve, put into plate a tablespoonful of sour cream, and add cold soup, stirring cream. Add chopped hard-boiled eggs. Favorite dish for summer.

18. Scrambled Eggs with Potatoes

3 eggs	3 tablespoonfuls milk
3 potatoes	$\frac{1}{2}$ teaspoonful salt
1 large onion	Pinch pepper
1 tablespoonful chicken fat	

APPENDIX

Cut up potatoes and onions and brown in pan with chicken fat. Add well-beaten eggs, milk, salt, and pepper. Stir until scrambled.

ARMENIANS, SYRIANS, TURKS, AND GREEKS

19. Matzaun or Yoghourt

2 quarts milk

1 tablespoonful old *matzaun*

Heat milk over a slow fire until it starts to boil; set aside to cool until blood-warm. Add one tablespoonful of old *matzaun* to start fermentation. Cover vessel with blanket to keep the milk warm during the process of fermentation.

In from two to three hours it will be done. It may be served hot or cold, and some people add sugar.

20. Ashoureh

1 pound wheat

$\frac{1}{2}$ to 1 teaspoonful rose-water

$1\frac{1}{2}$ pounds sugar

$\frac{1}{2}$ cupful seedless raisins

$\frac{1}{2}$ cupful hazelnuts, chopped

$\frac{1}{2}$ cupful pistachio nuts,
peeled

$\frac{1}{2}$ cupful walnuts, chopped

$\frac{1}{2}$ cupful almonds, chopped

1 to 2 pinches cinnamon, powdered

Soak the wheat in plain water for ten or twelve hours, then, after washing well, boil in newer water, twice of its measure, until it cracks. In a separate vessel boil the sugar in an equal quantity of water, until two thirds of it remains. To this add the raisins and the pistachio nuts. Then pour these all in the boiled wheat and continue boiling a while longer. When this is done take away from the fire and add the rosewater. Then chop well, add hazelnuts, walnuts, and almonds; roast a little in a pan on a moderate fire and spread over the boiled wheat mixture, meanwhile sifting on the powdered cinnamon.

21. Kolva

1 pound wheat

$\frac{1}{2}$ cupful almonds, chopped

$\frac{1}{2}$ cupful flour

$\frac{1}{2}$ cupful walnuts, chopped

1 cupful sugar

1 cupful fancy candy,

$\frac{1}{2}$ cupful raisins, seedless

mixed

IMMIGRANT HEALTH AND COMMUNITY

Soak the wheat in water for ten or twelve hours, wash well, and boil in newer water, but take away from the fire before it cracks. Strain and then spread on some white muslin overnight. Then roast the flour in a pan by itself until light brown, and when sufficiently cold add the sugar, also the almonds and the walnuts, which should be well chopped. Add this mixture to the boiled wheat, and mix in also the spiced fancy "grape shot" candy. (Serve cold.)

22. Wishneh (Cherry Preserve)

2½ pounds sugar	1½ pounds sour cherries,
1 pint plain water	freed from the stones
1 teaspoonful lemon juice	

Boil the sugar in the water over a moderate fire until it gets cream thick, then add the sour cherries (without the stones), also the lemon juice; after a little boiling take away from the stove and cool before placing in jars.

Note: *Retchel* can be prepared from all kinds of berries and fruits, especially from figs, pineapple, and even pumpkin, in same manner as described above.

23. Pilaf (Turkish)

5 cupfuls stock	2 tablespoonfuls butter
2 cupfuls rice	Salt and pepper to taste

In a deep vessel fry well the washed rice in the butter, then add the stock. When nearly done remove to back of stove to cook slowly. Cover with a piece of muslin under the lid, letting it fall a little over the brim to prevent the steam from falling back into the kettle. After ten minutes stir the rice lightly with a perforated spoon, then place over hot oven until moisture is evaporated and rice is almost dry. (Cracked wheat may be used instead of rice.)

24. Herissa (Armenian)

1 pound lamb or chicken	2 tablespoonfuls butter
10 cupfuls stock	3 pinches cinnamon
Pepper and salt to taste	

Take lamb or chicken meat without bones, boil for an hour or longer, shred into fine thready pieces with your fingers. Take the special wheat prepared for this purpose

APPENDIX

and soak in water from eight to ten hours, then boil in one half the broth of the chicken or lamb, gradually adding the rest of the broth. During the process of boiling it is necessary to stir and pound the mixture continually with a wooden spoon. When serving in plates pour over each share hot butter and powdered cinnamon to taste.

25. Lohano Basidi-Kelom

1 pound of fat, beef, mutton or lamb	2 ripe tomatoes (or 3 to 4 tablespoonfuls of canned tomatoes)
3 pounds cabbage	
2 dry onions, medium	3 cupfuls broth (or plain water)
Salt and red pepper to taste	

Cut the cabbage into egg-sized pieces and the meat into one half the size of the cabbage pieces. Also chop coarsely the onions and put them all, alternately, into a suitable vessel. Season with salt and the red pepper. Then after adding the cut tomatoes and the broth boil on a moderate fire until the meat and cabbage become very tender. (It is better to serve this *basidi* at least six to eight hours after cooking, when it should be reheated.)

26. Tureli Ghuvedge

1 pound of fat, mutton or lamb	1 bunch parsley
	$\frac{1}{2}$ bunch mint
1 pound eggplant	5 to 6 strips celery
$\frac{1}{2}$ pound green beans	3 to 4 ripe and unripe tomatoes
2 dry onions, medium	
Salt and red pepper to taste	

Clean all the vegetables properly and cut them into small sizes; do the same with the meat. Then put all in a deep, flat pan or a deep earthen vessel and, after seasoning the whole to taste, place in a moderately hot oven until well done. It is not necessary to use any broth or plain water with this *basidi*, as the ingredients will discharge enough water to be cooked in.

27. Patlijam Beoregh (Eggplant in Omelet Style)

1 eggplant, medium	2 to 3 tablespoonfuls hard cheese, grated
Butter in quantity to fry with	$\frac{1}{2}$ bunch parsley
2 eggs	Salt and pepper to taste

IMMIGRANT HEALTH AND COMMUNITY

Slice the eggplant in less than one-half-inch disks and fry slightly with butter in a large, flat pan. Then make a mixture of the eggs, the grated cheese, and very finely cut parsley and, after seasoning it to taste, pour it over each piece of the eggplant, and continue frying until brown on both sides.

28. Spinache

2 quarts spinach	1 cupful broth (or milk)
1 tablespoonful flour	2 to 3 slices bread (stale)
2 tablespoonfuls butter	Salt and pepper to taste

Clean the spinach, cut into pieces, wash well, boil for ten minutes, and put through cold water. Then fry the flour for ten minutes in the butter; to this add the spinach, also one half of the broth. After boiling this mixture for five to eight minutes, pour in the rest of the broth, stir slowly, and continue boiling for ten minutes longer. (Serve this hot with a little hot butter poured over it.)

The stale bread slices may be cut into square pieces and fried in butter and arranged over the spinach. The broth may be replaced with milk.

29. Tazeh Fassculia Yaghli (Green Beans with Olive Oil)

1 quart green beans	2 ripe tomatoes (or 3 to 4
3 dry onions, medium	tablespoonfuls of
1 green pepper, medium	canned tomatoes)
3 tablespoonfuls olive oil	Salt and pepper to taste

Clean and trim the beans, splitting them lengthwise, crush with some salt, and, after washing, arrange them in a suitable vessel. Slice over this the onions and the green pepper. Also add the juice of the tomatoes. Season to taste and, after pouring in the olive oil, boil on a moderate fire for ten to fifteen minutes, when one half of plain water should be added, and then left over a slow fire to simmer until done. (Serve hot or cold.)

30. Khiyar Dolma (Stuffed Cucumbers)

Pare eight to ten cucumbers of medium size, dig out their seedy parts with the aid of a narrow and pointed knife, stuff with the *dolma* mixture, and after piercing each one with a fork arrange in a suitable pan, side by side. Add

APPENDIX

two or three ripe tomatoes, cut into small pieces (or three to four tablespoonfuls of canned tomatoes), and then pour over one cupful or more of broth or plain water. Cook either on a slow fire or in a moderately hot oven.

Dolma mixture is made of equal parts of cooked rice and twice-ground, cooked meat, seasoned with parsley, salt, and pepper

Dressing: *terbieh*—made of one beaten egg and the juice of one lemon mixed—may be added to the whole, after blending the mixture first with part of the *dolma* gravy. (Serve hot.)

31. Tzouvatzegh (Armenian Egg Milk Toast)

6 to 8 slices bread, dry (or toasted)	Butter in quantity required for frying
1 cupful milk	3 or 4 eggs
Sugar to taste	

Dampen the dry bread with the milk and, after dipping into the beaten eggs, fry in smoking-hot butter on both sides. Some prefer only eggs and omit the milk; others use the milk with the beaten eggs mixed, the result of both methods being similar. (Serve with sugar or syrup if desired.)

32. Matzaun with Eggs

1 cupful <i>matzaun</i>	4 eggs
4 to 5 bulbs garlic, pressed	1 tablespoonful butter
Salt and pepper to taste	

Mix the juice of the garlic with the *matzaun* and hold ready in a large, flat plate. Then break the eggs into boiling-hot water, and let boil for five or six minutes, regular dropped-egg style, after which time take them out with the aid of a perforated spoon and arrange in the plate over the *matzaun*. This done, pour over the whole the butter, which should be smoking hot. Season to taste and serve at once.

33. Sudeli Youmourta

$\frac{1}{2}$ cupful sugar	4 eggs
2 cupfuls milk	1 orange, skinned
Salt and pepper to taste	

IMMIGRANT HEALTH AND COMMUNITY

Take a saucepan, put the milk in, and break the eggs into it. Add the orange, cut into pieces. Season to taste and stir well; then place the saucepan in a steamerful of boiling water. Cook this on a moderate fire until the mixture is fairly thick. Spread over it, lightly, some burnt sugar, and serve.

THE POLES AND OTHER SLAVIC PEOPLES

34. Kieśle

One quart of berries or grapes washed well and drained. Cover berries with cold water and cook until soft. Strain through cheesecloth. Add sugar to taste and set to cook; when boiling add two or three large tablespoonfuls of corn-starch. Set to cool. Serve with cream.

35. Ovsyanka

One quarter pound whole or cracked oats and enough water for five or six plates of soup. Boil with one onion when grain is soft, strain, add a lump of butter and a little milk; serve with croûtons. A few dry mushrooms chopped fine (well washed) add to flavor and taste of soup.

36. A Cold Soup, or Floating Island

Boil a quart of milk. Beat the whites of eggs stiff and add one tablespoonful of sugar. Drop the whites off the spoon into the boiling milk. When the mixture boils remove the whites with a perforated spoon and put into a bowl. Take the three yolks and rub until white with one half glass of sugar. Dilute with one quarter glass of cold milk and add to boiled milk, stirring constantly so yolks don't curdle. Keep on slow fire until somewhat thick, but not boiling—add for flavor either cinnamon or vanilla. Set on ice and serve with the whites. This makes a good dessert.

37. Flaxseed oil with a small amount of lemon juice is a favorite salad dressing.

INDEX

A

- Accident Prevention:
 - For immigrants, 352-357
- Adams, Samuel Hopkins, 163
- Advertising:
 - Quack, 147-163, 165-166
- African:
 - Insanity, 39
 - Malnutrition, 38
- Age:
 - Death rate, 47
 - Morbidity, 35
 - Nativity distribution, 42
- Agriculture:
 - Workers, 124
- Akron, Ohio:
 - Health work, 290
- Alabama:
 - Midwifery, 205
- Albany, New York:
 - Health work, 377
- Alcoholism:
 - Among foreign born, 39, 48
 - Among Irish, 56
- American Association for Labor Legislation, 401
- American Association of Foreign-language Newspapers, 169-170
- American Association of Hospital Social Workers
- American Dietetic Association, 312, 434
- American Hospital Association, 277, 430, 434
- American Medical Association, 163, 434
- American Medical Directory, 121, 135, 305
- American Public Health Association, 296, 431, 437
- American Red Cross:
 - Health program, 413, 435-436
 - "Housing in Italy," 90
- American Social Hygiene Association, 297, 435
- Americanism:
 - Definition, 23
- Americanization:
 - Agencies
 - Cleveland Committee, 296, 417
 - Definition, 8-10, 243, 429, 446-448
 - Factors, 440-443
 - Instruments, 276
 - Theories of procedure
 - Big Stick, 10-15
 - Laissez-faire, 15-18
 - The Democratic, 18-23

IMMIGRANT HEALTH AND COMMUNITY

- Amoskeag Manufacturing Company:**
 Accident prevention, 355
- Arabic:**
 Quacks, 150
- Arizona:**
 Midwifery, 205
- Arkansas:**
 Midwifery, 205
- Armenian:**
 Diets for sick, 269-270
 Documents, 279
 Food habits, 264-268
 Heritages, 122
 In Fresno, California, 75
 Midwives, 212
 Quacks, 150
- Armstrong, Donald B., 54,**
 421-428
- Auerbach, Samuel M., xxvi**
- Austria:**
 Infant mortality, 185
- Austrian:**
 Birth rates, 185
 Death rates, 45, 47, 61
 Infant mortality, 186
 Midwives, 197, 212
- B**
- Baker, S. Josephine, 200, 203**
- Balch, Emily G., 116**
- Baltimore:**
 Dispensaries, 331
 Quack advertising, 168
- Beaumont, Texas:**
 Health work, 378
- Belgium:**
 Midwifery, 199
- Benefit Societies, 92-111**
 In industry, 357-360
- Bimanski, Francis A., 292-294**
- Birth rates:**
 Foreign born, 184-187, 439
- Boarders:**
 In immigrant households, 81-82, 364
- Boards of Health:**
 Control of midwife, 206
 Sanatorium report, 313
- Boas, Franz, 438-439**
- Bohemian:**
 Birth rate, 186
 Boarders, 81
 Death rates, 44, 48, 51, 186
 Food habits, 248
 Geringer Press, 168
 Health care, 331
 Phrase book, 291
 Physicians, in Chicago, 136-137
 Quacks, 150
- Boston:**
 Benefit societies, 100
 Committee on Prenatal Care and Obstetrics, 233
 Death rates, 47, 56
 Dispensary
 Nativity of clientele, 330
 Jews using, 332
 The Maverick, 386
 Lying-in Hospital, 229
 Midwifery, 196
 Physicians, foreign-born, 137
 Quacks, 149
- Bowling Green Neighborhood Association, 381**
- Bridgeport, Connecticut:**
 Health work, 379

INDEX

Bright's Disease:

Death rate, 48

Brockton, Massachusetts:

Infant death rate, 62

Brown, Adelaide, 201

Brown, Walter H., xxvi

Buffalo, New York:

Health centers, 385

Health work, 290, 300

Midwifery, 206

Polish hospitals, 322

Bulgaria:

Infant mortality, 185

Bureau of Labor Statistics, xxvi:

Family incomes, 394

Sickness of wage earners, 28

Burgess, Ernest W., 29

C

California:

Climate, 253

Industrial health work, 345

Midwifery, 198, 201-202

California Commission of Im- migration and Hous- ing, 75-76, 177, 367

Canadian:

Births attended by mid-
wives, 197

Death rate, 47, 51, 186

Cannon, M. Antoinette, xxvi

Cedar Rapids, Iowa:

Quack advertising, 168

Chadsey, Mildred, 89

Chapin, Charles V., 212, 218

Charity Organization Society of New York, 301

Chicago:

Annual births, 232

Benefit societies, 103-107

Department of Health,
177

Dispensaries, 331

Hospitals

Cook County, 292

Jewish "Kosher," 322

Lying-in, 229, 230

Michael Reese, 322

Polish, 322

Industrial health work,
345

Midwifery, 198

Physicians' testimony, 138,
140

Physicians, foreign-born,
135-136, 138

Quacks, 149

Advertising, 167-168

Children's Bureau:

Infant mortality studies,
60-63, 83-84, 189, 198

Report on midwifery, 212,
250

Church:

Benefit societies, 95, 97-99

Cincinnati, Ohio:

National Social Unit, 387-
390, 408, 415

Circulatory Disease:

Death rate, 48

Cleveland, Ohio:

Americanization Commit-
tee, 296, 417

Dispensaries, 311

Health centers, 384-385

Industrial health work, 345

Polish hospitals, 322

Visiting Nurses' Associa-
tion, 291

IMMIGRANT HEALTH AND COMMUNITY

Clinic:

- Factory, 358
- Food, 339
- Industrial, 424-425
- Medical, 425-426
- Of labor unions, 359
- Prenatal, 221-223, 422-423
- Public health, 327
- School, 423-424

Colorado:

- Industrial health work, 345
- Colorado Fuel & Iron Co.:
 - Health plan, 371
- Committee on the Prevention of Tuberculosis, 301

Community:

- Administration of health work, 404-413, 419-428
- Hospital service, 323-325
- Industrial health work, 371-375
- Maternity care, 233-246
- Medical service, 342-343
- Physicians per population, 136

Connecticut:

- Midwifery, 206
- Physicians, 138

Constipation:

- Diets for
 - Armenian, 269
 - Greek, 269
 - Italian, 256
 - Jewish, 262
 - Polish, 273
 - Slavic, 273
 - Syrian, 269
 - Turkish, 269

"Contract System":

- In industrial health work, 369-370

Co-operation for:

- Immigrant health work, 414-417

- Maternity care, 243-245

Cramp, Arthur J., 174

Croatian:

- Benefit societies, 104-105
- Boarders, 81, 364
- Heritages, 115-116
- Quacks, 150

Czecho-Slovaks:

- Benefit societies, 102, 105

D

Danish:

- Newspaper
 - Den Danske Pioneer*, 167

Davenport, C. B., 442-443

Davis, Janet Hayes, xxvi

Davis, Michael M., Jr., 380

Davis, William A., 47, 56

Davis and Warner, 326

Death rates:

Cause, 35, 43-63, 184-187

Infant, 214

Native and foreign-born, 440

Delaware:

Midwifery, 205

Democracy:

Americanization in, 18-23

Dempsey, Mary V., 62

Denmark:

Infant mortality, 185

Midwifery, 200

Denver:

Health work, 377

INDEX

- Departments of Health:
 Controlling medical quacks, 179-183
 Questionnaire on housing, 85-89
 Use of foreign-language literature, 289
 Work with foreign born, 376-385
- Department of War:
 Examination of drafted men, 31-34
 Quack advertising, 159
- Detroit, Michigan:
 Health work, 287
 Home Nursing Association, 188, 198, 201
 Maternity survey, 183, 188, 201
 Midwifery, 198
 Polish hospitals, 322
 Quacks, 150
 Semet - Solvay Company, 353
- Diabetes:
 Diets for
 Armenian, 269-270
 Greek, 269-270
 Italian, 257
 Jewish, 262
 Polish, 273
 Russian, 273
 Slavic, 273
 Syrian, 269-270
 Turkish, 269-270
- Diets:
 Immigrant, 246-279, 311-313
- Digestive Diseases:
 Death rate, 48
- Disease (*see* Sickness)
- Dispensaries, 326-342
 Definition, 176
 Licensing, 176-177
 Socialization, 338-339
- District of Columbia:
 Midwifery, 205, 218
- Drugstore:
 Relation to foreign born, 131-133
- Dublin, Louis I., 46-47, 49, 51
- Duluth, Minnesota:
 Foreign physicians, 136
- Duke, Emma, 62, 83-84, 189, 198
- Duncan, Beatrice Sheets, 62, 84
- ## E
- Eastman, P. R., 59, 185
- East Orange, New Jersey:
 Malnutrition, 38
- Elkus, Abram I., 79-80, 88
- Emmons 2d, A. B., 210
- Endicott, Johnson & Co.:
 Health work, 360
- England:
 Health study, 362-363
 Midwifery, 200
- English:
 Births attended by midwives, 197
 Death rates, 45, 47-49, 51, 186
 Malnutrition, 38
 Phrase book for health work, 291-292
- Enuresis:
 Diets for Jewish, 261

IMMIGRANT HEALTH AND COMMUNITY

Erie, Pennsylvania:
 Health work, 378

Europe:
 Physicians, 121

F

Fairchild, Henry Pratt, 114

Finnish:
 Physicians, 136
 Quacks, 150

Fitchburg, Massachusetts:
 Health work, 288

Florida:
 Midwifery, 205

Ford, Henry, 354

Foreign born:
 Midwifery, 197-203

Foreign language in:
 Accident prevention, 355-356

 Diet work, 276-277
 Health work, 289-294

Foreign-language newspapers:

 Quack advertising, 147-153, 164-170

Foresters:
 Benefit societies, 94

Fosdick, Raymond, x

Framingham, Massachusetts,
 Study, 54-55, 408, 421-423

France:
 Infant mortality, 185
 Midwifery, 199

Fraternal Order of Eagles:
 Benefit societies, 94

French:
 Death rates, 44, 48, 51, 186

Newspaper
 Le Courier Franco-Américain, 167

Quacks, 149, 150

French-Canadian:
 Boarders, 81

Fresno, California:
 Immigrant colony, 75-76

G

Galicia:
 Jewish diets, 260

Gay, Edwin F., x

Georgia:
 Midwifery, 205

German:
 Benefit societies, 105
 Births attended by midwives, 197

 Boarders, 81
 Death rates, 44-51, 54, 186

 Health care, 333
 Health centers, 387

 Infant mortality, 185
 Insanity among, 39

 Malnutrition, 37-38
 Midwives, 212

 Phrase book for health work, 291

 Quacks, 150

Germany:
 Infant mortality, 185
 Jewish diets, 259

 Midwifery, 197

Glen, John M., x

Goodrich Company:
 Health work, 360

Goodyear Tire & Rubber Co.:

 Employee housing, 363

INDEX

- Government:**
 Immigrant's relation to, 121-122
- Great Britain:**
 Health-insurance legislation, 403
 Infant mortality, 185
- Greeks:**
 Benefit societies, 98, 101-102, 105
 Boarders, 82, 364
 Diets for sick, 268-270
 Food habits, 264-267
 Health care, 331
 Heritages, 114
 Newspapers
 Atlantis, 167
 Star, 167
 Physicians, 135, 137
 Quacks, 150, 160-161
 Guilfoy, William H., 44-45, 49-50, 54, 60
- H**
- Haasis, Bessie Ammerman**, xxvi
- Harris, Louis**, 359
- Harvard Medical School** xxvii
- Health:**
 Co-operation for, 414-417
 Effect of occupation, 124
- Health Centers in**, 328
 Buffalo, 386-387
 Cleveland, 384-385
 New York, 380-384, 405
- Health Insurance:**
 In medical care, 401-404
- Health work:**
 Administration, 404-406
 Localization of, 299-302
- Factors**, 3-10, 126-128
- Field agent**, 283-304
- Immigrant**, 330-334
 Diets, 274-279
 Limitations, 393-401
 Resources, 129-142
- Industrial**, 344-375
- Problems**, 117-120
- Public**, 376-385
- Significance**, 117-120, 439-448
- Small community**, 419-428
- Training**, 432-433
- Henry Street Settlement:**
 Health study, 34-36
- Heritages** (*see* Immigrant)
- Holland:**
 Jewish diets, 259
 Midwifery, 199
- Homes:**
 Industrial health work, 360-362
 Medical resources, 130-131
- Homestead, Pennsylvania:**
 Quack advertising, 168
- Horak, J.**, 94, 104-107
- Hospital:**
 Cook County, Chicago, 292
 Health care, 101-102, 333
 Immigrant attitudes, 121, 306-311
 Infant death rate, Newark, 214
 Licensing, 176-177
 Localization, 323
 Maternity, 219-222
 Socialization, 318-321
 Work for immigrants, 305-325

IMMIGRANT HEALTH AND COMMUNITY

Housing:

- Effect on health, 82-89
- Factors, 72-75, 89-91
- For foreign born, 70-80
- Fresno, California, 75-76
- Government, 78
- Relation to industry, 362-371

Howard, Clarence H., 354

Hungarian:

- Benefit societies, 93, 105
- Birth rate, 186
- Births attended by midwives, 197
- Boarders, 81, 231
- Death rates, 44-48, 50-51, 54
- Drugstore, 131-133
- Health centers, 387
- Newspaper
Magyar Munkaslap, 167
- Physicians, 137
- Quacks, 150
- "The Hungarians of Cleveland," 296

Hungary:

- Infant mortality, 185

Huntington, J. L., 210

I

Idaho:

- Midwifery, 205

Illinois:

- Medical service, 370
- Midwifery, 206
- Quacks, 167-168

Illinois Health Insurance

Commission:

- Benefit societies, 94, 103, 106-107

Sickness of wage earners, 28-30

Immigrant customs:

- Diets, 246-279
- Maternity, 191-193

Immigrant heritages, 112-123

Attitude, 121, 306-311, 328-330

Importance in health work, 294-299

Immigrant newspapers (*see separate races*)

Immigrant organizations:

- Benefit societies, 92-111

Immigrant problems:

- Income, 394-396
- The quack, 145-183

Immigration:

- "Old" *versus* "new," 6, 184-185

Indiana:

- Midwifery, 206

Industry:

- Health insurance, 401-404
- Health work, 344-375
- Workers, 124, 344
- Homes for, 78

Infant mortality:

- Bad housing, 83-84
- By nationality, 42, 58-63
- In European countries, 185
- Midwifery, 211-216

Infections:

- Death rate, 51

Insanity:

- Among foreign born, 39-40

International Harvester Companies:

INDEX

- Employees' Benefit Association, 357**
- Interpreters:**
 In health work, 241, 286-289, 313-318
- Irish:**
 Alcoholism, 86
 Births attended by midwives, 197
 Boarders, 81
 Death rates, 43-57, 61, 186
 Health care, 333
 Health center for, 381
 Insanity, 39-40
 Malnutrition, 38
 Mortality, 56-57
- Italian:**
 Attitude, 307, 329, 331-333
 Benefit societies, 93, 99-100, 105
 Birth rate, 186, 439
 Births attended by midwives, 197
 Boarders, 81
 Commission for health work, 301-302
 Death rates, 35, 45-52, 61, 186, 187
 Diets for sick, 256-257
 Food habits, 253-255
 Health care, 331, 333
 Health center, 384
 Heritages, 113, 124
 Hernia, 352
 Hospital, 322
 Housing conditions, 85
 In agriculture, 420
 Insanity, 39-40
- Malnutrition, 37-38**
- Maternity care, 231**
- Maternity customs, 192-193**
- Midwifery, 197-198, 211-212, 218**
- Phrase books, 291**
- Physicians, 108, 135, 137**
- Quacks, 150**
- Sickness, 34-39**
- Italy:**
 Food habits, 253-255
 "Housing in Italy," 90
 Infant mortality, 185
 Midwifery, 199
- J**
- Jacobi, Abraham, 214**
- Japanese:**
 Hospital in San Francisco, 322
 Midwifery, 198
 Physicians, 322
- James, Linda, xxv**
- Jenks and Lauck, 81, 344, 353, 365**
- Jewish:**
 Attitude, 330, 331-332
 Benefit societies, 93, 97, 101, 105
 Birth rate, 439
 Boarders, 81
 Death rates, 49
 Diets for sick, 261-264
 Food habits, 257-261
 Health care, 330-332, 381-384
 Heritages, 116-117, 122
 Hospitals, 321-323
 Insanity, 39-40

IMMIGRANT HEALTH AND COMMUNITY

- Malnutrition, 87
 - Maternity care, 231
 - Maternity customs, 192-193
 - Midwifery, 218, 220
 - Physicians, 100, 135, 137
 - Quacks, 150
 - Sickness, 85-86
 - Johnstown, Pennsylvania:
 - Infant mortality study, 62-63, 83-84, 189, 198
 - Joint Board of Sanitary Control, New York City, 358
 - Journal of Industrial Hygiene*, 350
- K**
- Kentucky:
 - Midwifery, 205
 - Knoepfel, Charles E., 347
 - Krasnow, H. R., 146, 168
- L**
- Labor camps, 365-368
 - Labor Sanitation Conference, New York City, 359
 - Labor Unions:
 - Health work, 358
 - Language:
 - Factor, in health work, 126-127, 286-294, 336
 - Legislation:
 - Health
 - Federal
 - Fraud Order law, 171-172
 - Pure Food law, 173-174
 - State
 - Control of quack, 175-176
 - Industrial health insurance, 401-404
 - Midwife, 205-210
 - Leiserson, William M., 365
 - Lettish:
 - Attitude, 308
 - Levy, Julius, 207, 212
 - Lewinski-Corwin, E. H., 141, 230-231, 332
 - Lithuanian:
 - Attitude, 308-309
 - Benefit societies, 94, 105
 - Boarders, 81, 364
 - Health care, 331
 - Heritages, 113
 - Jewish diets, 260
 - Physicians, 135
 - Quacks, 150
 - Los Angeles, California:
 - Midwifery, 206
 - Louisiana:
 - Health work, 289
 - Midwifery, 206
 - Lovell, Bertha G., 339
 - Loyal Order of Moose:
 - Benefit societies, 93
- M**
- McNutt, J. S., 84
 - Magyar (*see* Hungarian)
 - Maine:
 - Health work, 289
 - Midwifery, 205
 - Malnutrition:
 - Children, 87-88

INDEX

- Diets for**
 - Armenian, 268
 - Greek, 268
 - Italian, 257
 - Jewish, 261
 - Polish, 272-273
 - Slavic, 272-273
 - Syrian, 268
 - Turkish, 268
- Manchester, New Hampshire:**
 - Health work, 290, 300
 - Infant mortality, 62-63, 84
- Manny, Frank A., 37**
- Maryland:**
 - Midwifery, 206
- Massachusetts:**
 - Health work, 289
 - Licensing dispensaries, 176-177
 - Midwifery, 205
- Massachusetts Bureau of Immigration:**
 - Medical frauds, 179
- Maternity Care:**
 - Agencies, 187-190, 218-245
 - Customs, 191-194
 - Proposed plan, 233-245
 - Training
 - Nurses, 238
 - Physicians, 225-226, 230-231
- Maternity Center Association of New York:**
 - Work, 223-225, 238
 - Midwifery study, 219
- Maverick Dispensary, 196**
- May, Charles C., 362-363**
- Maynard, Massachusetts:**
 - Foreign-born physician, 136
- Memphis, Tennessee:**
 - Midwifery, 207
- Menus:**
 - Immigrant, 277-278, 311-313
- Metropolitan Life Insurance Company, 27**
- Mexicans:**
 - Texas, 299
 - In labor camps, 367
- Michigan:**
 - Industrial health work, 345, 368-370
 - Midwifery, 205
- Midwife (The), 196-217**
 - Births attended, 196-197
 - Distribution by nationality, 212
 - European, 199-200
 - Legislation, 205-210
 - Substitutes, 218-243
 - Testimony of physicians, 211-214
 - Work, 196-200, 210-217
- Minneapolis, Minnesota:**
 - Quack advertising, 167
- Minnesota:**
 - Industrial health work, 345, 368-370
 - Midwifery, 206
- Mississippi:**
 - Midwifery, 205
- Missouri:**
 - Midwifery, 2-6
- Mock, Harry E., xxvi, 350**
- Morbidity (*see* Sickness)**
- Morgan Park, Minnesota:**
 - Housing, 364

IMMIGRANT HEALTH AND COMMUNITY

Mortality:

Foreign born, 56-58

Need for data, 63-69

Mother Tongue:

Classification, 6, 66-67

N

National Organization for
Public Health Nursing,
xxvi, 291, 433-437

National Safety Council:

Accident prevention, 353

National Tuberculosis Asso-
ciation, 296, 435

Nebraska:

Midwifery, 205

Negro

Health care, 333

Neighborhood:

Dispensaries, 342-343

Factor in health work, 300-
302

Maternity centers, 225

Medical resources, 130

Nephritis:

Diets for

Armenian, 269

Greek, 269

Italian, 256

Jewish, 262

Polish, 274

Slavic, 274

Syrian, 269

Turkish, 269

Netherlands:

Infant mortality, 185

New Hampshire:

Midwifery, 205

New Haven, Connecticut:

Health work, 289

New Jersey:

Midwifery, 206-207

New Mexico:

Midwifery, 205

New York:

Births attended by mid-
wives, 197

Health work, 289

Insanity among the foreign
born, 39-40

Licensing dispensaries, 176-
177

Maternity care, 218

Midwifery, 206

Quack advertising, 167

New York City:

Association for Improving
the Condition of the
Poor, 188, 198, 202

Dispensaries, 330

Examination of drafted
men, 33

Health care, 332

Health centers, 380-384

Hospitals

Bellevue, 204-205

Italian, 322

Jewish, 322

Joint Board of Sanitary
Control, 358

Labor Sanitation Confer-
ence, 359

Malnutrition of school chil-
dren, 37, 38

Midwifery, 202

Mortality

By nationality, 45-46

Of children, 61

Physicians, 38-39

Quacks, 149

INDEX

- Sickness among Jews, Ital-
ians, 34-36
Study of childbirth, 189
New York City Department
of Health:
Health experiment, 3803-84
Industrial health, 359
Medical fraud, 179-180
Mortality, 50
New York Milk Committee,
381
New York State Bureau of
Industries and Immi-
gration:
Quacks, 153, 160-162, 180-
181
New York State Department
of Health:
Births attended by mid-
wives, 197
Foreign - language litera-
ture, 289
Infant mortality, 59-60
Study of birth rates, 185-186
New York State Hospital
Commission:
Insanity among foreign
born, 39-40
New York State Reconstruc-
tion Commission:
Tenement House Survey
79-80, 88-89
Newark Department of
Health:
Infant death rate, 214
Midwifery, 196, 213-214,
243
Newark, New Jersey:
Health work, 378
Midwifery, 207-210
Nightingale, Florence:
Contribution to nursing,
237
Norfolk, Virginia:
Midwifery, 206
North Adams, Massachu-
setts:
Health work, 377
North Dakota:
Midwifery, 205
Norton Company, Worces-
ter, Massachusetts:
Health work, 360
Norway:
Infant mortality, 185
Midwifery, 200
Norwegian:
Newspaper
Tidende, 167
Quacks, 150
Nurses:
Community work, 412
Foreign born, 284-286
Foreign-language speaking,
290
In health work, 379
In industry, 361
Maternity, 223-240
Service to foreign born, 433
Textbooks, 276-277, 291-
292
Training, 238

O
Occupation:
Change in, 124
Of foreign born, 344
Ohio:
Licensing dispensaries, 176-
177

IMMIGRANT HEALTH AND COMMUNITY

- Medical service, 370
- Midwifery, 204, 206
- Ohio Health Insurance and
Old Age Pension Com-
mission:
 - Benefit Societies, 28-29,
97-98
 - Nationality of Physicians,
136
- Oklahoma:
 - Midwifery, 205
- Omaha, Nebraska:
 - Midwifery, 206
 - Quack advertising, 167
- Oregon:
 - Midwifery, 205
- Organizations, Immigrant
(*see* Immigrant)
- Out-patient Work:
 - In hospitals, 326
 - In maternity care, 219, 225
- P**
- Paine, Alonzo K., 226, 233-
241
- Pennsylvania:
 - Health work, 289
 - Industrial health work, 345
 - Medical service, 370
 - Midwifery, 198
 - Sickness of wage earners,
28
- Pennsylvania Health Insur-
ance Commission:
 - Benefit societies, 95
- Pennsylvania Railroad:
 - Accident prevention, 356
- Perkins, Frances, 238-241
- Philadelphia:
 - Benefit societies, 100
- Dispensaries, 330
- Health work, 295
- Midwifery, 213
- Physicians:
 - Foreign, 134-137, 339
 - Industrial, 346-349, 369-
370
 - Japanese, 322
 - Maternity care, 196, 211-
214, 219-223, 233-
235, 239-240
 - Points of view, 307
 - Ratio to population, 121
 - Training for maternity
care, 225-226, 230-
231
 - Use by foreign born, 136-
142
 - Work in benefit societies,
108-109
- Pittsburgh:
 - Quacks, 149, 156
- Pneumonia (*see* Respiratory
diseases)
- Poland:
 - Jewish diets, 259
- Polish:
 - Attitudes, 307, 329, 351
 - Benefit societies, 94, 97-99,
105
 - Birth rate, 186, 489
 - Births attended by mid-
wives, 197
 - Boarders, 81, 364
 - Childbirth study, 189-190
 - Death rates, 44, 48-51, 61,
186
 - Diets for sick, 272-274
 - Food habits, 252, 270-
272.

INDEX

- Health care, 331, 333
 - Health center for, 385
 - Heritages, 113, 115, 121-123
 - Hospitals, 322
 - In agriculture, 420
 - Maternity customs, 191
 - Midwifery, 212
 - Phrase books, 292-293
 - Physicians, 135-138
 - Quacks, 150, 154-155, 397
 - "The Poles of Cleveland," 296
 - Polish National Alliance, 94
 - Population:
 - Age distribution, 42
 - Classification for foreign born, 66-67
 - Increase by mother tongue, 6
 - Ratio
 - Of medical schools, 232
 - Of physicians, 121, 135-136
 - Portugal:
 - Jewish diets, 259
 - Portuguese:
 - Benefit societies, 93, 102-103
 - Physicians, 109
 - Quacks, 150
 - Post Office Department:
 - Control of medical quack, 171-172
 - Prague, Oklahoma:
 - Quack advertising, 168
 - Price, George M., 358
 - Providence, Rhode Island:
 - Foreign-born physicians, 136
 - Health work, 288
 - Midwifery, 212, 218
- Q**
- Quack:
 - Among immigrants, 145-183, 397
- R**
- Ranson, John E., 331
 - Ravage, Marcus E., 70, 72, 116-117
 - Recipes, immigrant, 449-463
 - Respiratory disease:
 - By nationality, 35-36, 40-41
 - Death rate, 51-52
 - Rhode Island:
 - Midwifery, 205
 - Rickets:
 - Among Italian children, 37-38, 40
 - Roberts, Peter, 185, 351
 - Roosevelt, Theodore, x
 - Rumania:
 - Jewish diets, 260
 - Rumanian:
 - Boarders, 82, 364
 - Health centers, 387
 - Rushmore, Stephen, 226, 233-241
 - Russia:
 - Food habits, 252
 - Infant mortality, 185
 - Jewish diets, 259-260
 - Russian:
 - Attitudes, 307
 - Benefit societies, 105
 - Birth rate, 186

IMMIGRANT HEALTH AND COMMUNITY

- Births attended by midwives, 197
 - Death rates, 44-45, 186
 - Diets for sick, 273
 - Heritages, 113
 - Malnutrition, 38
 - Midwifery, 212
 - Mortality, 57-58
 - Newspaper
 - Amerikansky Russky Vestnik*, 168
 - Physicians, 137
 - Quacks, 146, 150
 - Ruthenian:
 - Boarders, 81
- S**
- St. Louis, Missouri:
 - Commonwealth Steel Company, 354
 - Dispensaries, 331
 - Health work, 295
 - San Francisco, California:
 - Dispensaries, 331
 - Japanese hospital, 322
 - Quacks, 149, 153
 - Sartorio, E. C., 114
 - Scandinavian:
 - Benefit societies, 105
 - Death rates, 44, 48, 51, 186
 - In agriculture, 420
 - School, Medical, 225-230
 - School, Public:
 - Elementary
 - Health work, 423-424
 - Scotch:
 - Births attended by midwives, 197
 - Death rates, 44, 47-49, 51, 54, 186
 - Selby, C. D., 349
 - Semet-Solvay Company of Detroit:
 - Accidents among immigrants, 353
 - Serbians:
 - Benefit societies, 105
 - Boarders, 82, 364
 - Serbo-Croatian:
 - Infant Mortality Study, 189, 190
 - Schapiro, Mary L., 258-264, 451-457
 - Shenandoah, Pennsylvania, 294
 - Sickness:
 - Amount, 31-32, 35-36
 - Cures by quacks, 148-149
 - Duration, 28-30
 - Economic loss, 27-28
 - Need for data, 63-69
 - Slavic:
 - Benefit societies, 93
 - Diets for sick, 272-274
 - Food habits, 270-272
 - Health care, 333
 - Health centers, 384
 - In agriculture, 420
 - Insanity, 39-40
 - Maternity care, 231
 - Midwifery, 199
 - Newspaper
 - Amerikansky Russky Vestnik*, 168
 - Slovak:
 - Benefit societies, 105
 - Boarders, 81
 - Heritages, 113, 116, 122
 - "New Times" Publishing Company, 167

INDEX

Quacks, 150
 "The Slovaks of Cleveland," 296
 Slovenian:
 Benefit societies, 95, 105
 Soble, Jacob, 198
 Social Service:
 Dispensary, 338-339
 Hospital, 318-321
 Social Unit, 387-390, 408, 415
 South Carolina:
 Midwifery, 205
 South Dakota:
 Midwifery, 205
 Spain:
 Jewish diets, 259
 Spanish:
 Phrase book, 291
 Springfield, Massachusetts:
 Health work, 288, 377
 Stebbins, Elwyn, 201
 Stella, Antonio, 38, 52, 55
 Sullivan, Louis R., 33
 Sweden:
 Midwifery, 200
 Swedish:
 Anæmia, 352
 Malnutrition, 38
 Quacks, 150
 Switzerland:
 Infant mortality, 186
 Syrian:
 Diets for sick, 269-270
 Food habits, 264-268
 Health centers, 381
 Heritages, 122

 T
 Tennessee:
 Midwifery, 205

Texas:
 Baby clinic, 299
 Midwifery, 205
 Thomas, and Znaniecki, 115
 Topeka, Kansas:
 Foreign - language phrase books, 291
 Tuberculosis:
 Death rate, 53-55
 Diets for
 Armenian, 269-270
 Greek, 269-270
 Italian, 256-257
 Jewish, 263
 Polish, 274
 Slavic, 274
 Syrian, 269-270
 Turkish, 269-270
 Preventive work with Italians, 301-302
 Tufts Medical School, 230
 Turkish:
 Diets for sick, 269-270
 Food habits, 264-268

U

Ukrainian:
 Attitudes, 329-330
 United States Census, 6, 42, 43, 44, 48, 51, 54, 59, 105, 186, 187, 431
 United States Chamber of Commerce:
 Accident prevention, 354-356
 Industrial housing, 366
 United States Commission on Industrial Relations:
 Sickness of wage earners, 28

IMMIGRANT HEALTH AND COMMUNITY

- United States Department of Labor:
 "Human relations in industry," 375
- United States Immigration Commission:
 Boarders in immigrant households, 81-82
 Co-operation with hospitals, 197
 Fecundity of Immigrant Women, 184-185
 Immigrants in industries, 344-353
- United States Public Health Service, xxvi, 368, 435
- University Hospital of San Francisco, 322
- Utah:
 Midwifery, 206
- V
- Van Blarcom, Carolyn, 200, 205
- Veiller, Lawrence, 301
- Vermont:
 Midwifery, 205
- Virginia:
 Midwifery, 205
- Visiting Housekeeper, 240
- Visiting Nurses' Association:
 Cleveland, Ohio, 291
 Topeka, Kansas, 291
- Voll, John A., x
- W
- Wald, Lillian, 294
- Waller, Edith:
 English - Italian phrase book, 291
- Waller, H. T., 363
- War:
 Effect, 8
- Watson, Elizabeth C., xxvi
- Welsh:
 Births attended by midwives, 197
 Death rates, 44, 48, 51, 54
- Western Reserve University, 384
- West Virginia:
 Midwifery, 205
- Whitensville, Massachusetts:
 Industrial village, 78
- Wiley, Harvey, 163
- Williams, J. Whitridge, 214-215
- Williams, Talcott, x
- Williams, Whiting, 375
- Wisconsin:
 Floating labor camps, 365-367
 Midwifery, 204, 206
 Park Falls Lumber Company, 366-367
- Women:
 Immigrant
 Benefit societies, 96-100
 Death rates, 186-187
 Fecundity, 184-187
 Organizations, 276
 Program
 Physicians, 223
- Woods, Bertha M., xxvi
- Worcester, Massachusetts:
 Health work, 287
- Wyoming:
 Midwifery, 206

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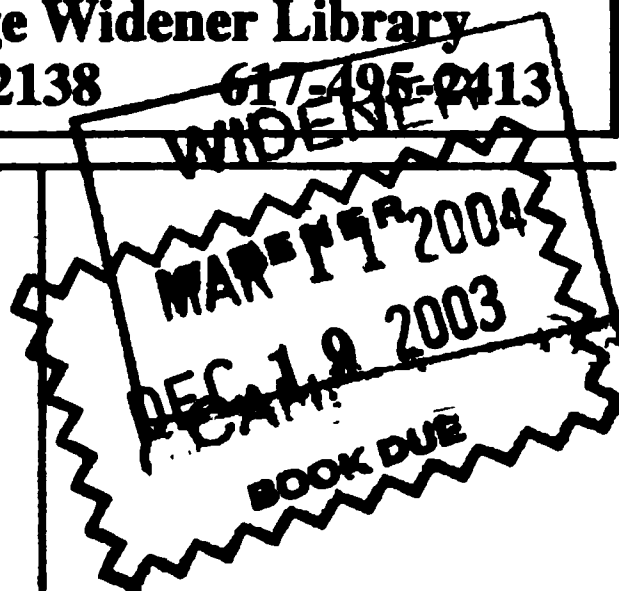
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